

forum

N C M E D I C A L B O A R D

DESMOTERIC MEDICINE:
A.K.A., CORRECTIONAL HEALTH CARE
See Page 5



President's Message

Paul Saperstein

Before I begin my final President's Message, I would like to express the Board's deep concern about the disaster that has struck eastern North Carolina. Nothing one can say can assuage the pain, sorrow, and loss felt by so many thousands of our fellow citizens. But there is inspiration and a sense of pride in the way the people of the whole state have come together to lend aid of all kinds and caring hands to those who have suffered so much. By working together, we can ensure that the nightmare will end and a Carolina morning will follow.

I hope you will take a moment to read the article, Hurricane Floyd, that our executive director, Mr Watry, has prepared to address several questions that have come to us since the hurricane and flooding hit. It appears on page 10.

An Honor and a Privilege

By the time this article reaches you, my term of office as president of the North Carolina Medical Board will be all but over. It is with a great amount of pride that I can say that everything in the realm of Board responsibilities is alive and well.

When asked to serve as the Board's first non-physician president approximately one and a half years ago, I was unsure how I would be received—not only by the Board staff, but also by physicians, physician assistants, and nurse practitioners. I quickly found that any concerns I might have had in this area were unfounded; my not being a health care professional led to no opposition to my role as president. I feel the Board has added another dimension by allowing itself to avoid a preconditioned belief that the head of the Board needs to be a physician.

Serving on the Board over the last few years, I have seen a lot of changes that have enhanced our position as one of the top licensing boards—not only in the state, but in the nation. Under the leadership of our new executive director, Mr Andrew Watry, and his able assistant executive director, Ms Diane Meelheim, the Board, in its structure and operation, ranks as one of the outstanding boards in the country. We have been

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From the Executive Director



Andrew W. Watry

Dealing with Bureaucracy

Many people derive a negative connotation from the word bureaucracy. Indeed, *Webster's* gives you a choice between positive and not so positive definitions. Yet to manage, we often need bureaucracy. A bureaucracy keeps the office open, bills for services rendered, responds to consumers, and provides medical care. The Holy Grail is finding the right balance between meeting your organizational objectives effectively and doing so as efficiently as possible.

The North Carolina Medical Board's organizational objective is public protection, and it takes bureaucracy to achieve this objective. This often causes frustration that we would like to minimize. In the following paragraphs, I will offer some helpful hints that may be useful in reducing some of these frustrations or avoiding them entirely. These morsels of information will appear in italics.

In dealing with any bureaucracy, the object is to get to the end zone. If you are trying to get to the end zone at Kenan Stadium from Raleigh, there is a direct route on Interstate 40 that takes from thirty to forty-five minutes, depending on whether you violate the speed limit. There is an infinite number of indirect routes that could take you through communities such as Durham, Fayetteville, or Milwaukee and would take you anywhere from 45 minutes to several days. Dealing with a medical licensing board is not unlike this trip to Kenan Stadium. It could either surprise you and be a pleasant experience or it could totally frustrate you when you get caught in a major traffic jam. There are ways to avoid the major traffic jams. None of these mech-

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forum

N C M E D I C A L B O A R D

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

North Carolina Medical Board

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Dealing with Bureaucracy

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anisms are guaranteed, but they can affect the probability of your success. We want to assure you that all our Board members and staff are committed to getting you to the end zone expeditiously. Following are but a few suggestions that I hope you find helpful. The list is certainly not exhaustive and we solicit your comments and suggestions.

Getting Licensee Information

Most of us, when we need information from a bureaucracy, want to call that bureaucracy immediately, talk to a human being, and instantly get an answer. If no one answers the telephone, we assume the person on the other side is on a smoking break or an extended lunch. If we get the dreaded voice messaging system, we almost immediately assume failure and try to find the secret mechanisms that have been placed in that messaging system to punch out and get a human being.

We at the Board receive an average of 218,580 telephone calls a year, which breaks down to 18,215 calls per month. Yes, we have a voice messaging system that is designed to shorten the amount of time

we spend on the telephone. The intent is to be efficient. For calls that branch out of this system, we spend an average of 78 seconds per call. In theory, one person could handle an average of 369 of the 910 calls that come in each work day, but that is not realistic. There are two obvious options: doubling the number of staff available to handle telephone calls, or providing much more efficient mechanisms for responding to the bulk of calls. We are tilting toward the latter. The idea is to strike a good balance through the telephone system, getting callers to the end zone as quickly as possible.

The vast majority of calls are about simple information, such as a person's license status, application status, or registration status. I will use annual registration as a simple example. We have to print one and a half times as many annual registration forms as we have licensees. Fully 40% of our licensees call and ask for a second or even third mailing of their form. Many of these callers are angry, implying that the Board never mailed the registration form in the first place. I can tell you that this accusation simply does not make sense. Registration of a license accomplishes many purposes, including updating the Board's data on the licensee and asking the licensee probing questions about prob-

lem areas. However, it is also the principal source of revenue for the Board. It simply does not make sense that we would not mail registration forms. However, as third parties apply pressure to physicians and other licensees to keep their licenses current, out of an abundance of caution a lot of these registrants call and ask for a second mailing of the form. This means that, at a minimum, we receive 12,633 calls a year just to request a registration form, assuming that a licensee only makes one telephone call. Most of these calls, in 20/20 hindsight, are unnecessary because we mail the second form to the same address. Of course, we need to make it easier for licensees to get these forms should they need them. But here are some suggestions to help licensees avoid problems with annual registration forms.

- (1) *Make sure your mailing address on record with the Board is a good one. Having your mail come into a large institution such as a hospital or school increases chances it won't get to you.*
- (2) *Don't be unduly concerned until 15 days before your birthday. The forms are mailed 30 to 45 days in advance of your birth month.*
- (3) *If your forms are handled by others, please advise them of the importance of your registration material, which is mailed in special envelopes designed not to look like junk mail.*

We are devising alternate mechanisms for responding more quickly and efficiently to inquiries about registration and requests for duplicate registration forms. The first order of business has been to shift as much information as possible to the Web. *Please make a note of our Web address, which we list here and which we also list in every edition of the Forum: www.docboard.org/nc.* The registration data we have put on the Web should help minimize the need for a telephone call to the Board for the same information. We have also designed a space in the Registration section of our site to facilitate e-mail requests for additional registration forms. (The site is now a rich source of information, with details described in earlier *Forum* editions. There is a place to obtain a copy of our complaint form. There is a place to check on the status of a licensee. We want to encourage you to use our Web site as your first source for information. If you are able to get a quick answer to your question or inquiry, we have been successful.) We are also providing a voice mailbox so you can leave a message requesting forms in the event you cannot use the Web.

Applicants for a License

Other significant telephone queries come from applicants. We issue about 2,337 new

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licenses a year. One thing that is common with many of these applicants is the desire to start work yesterday. Most applicants allow the Board sufficient time to process an application, never make a query, and get a license without problems. However, I often receive calls from applicants who ask for expedited service, indicating that they have an immediate need to go to work but the Board is holding them up. When I check on the status of their application, I find that we received it within the past 48 hours. *This is a totally unrealistic expectation.* You don't get credentials at a major hospital or at any other licensing board nearly that fast. Also, we don't expedite one applicant at the expense of others. From a management standpoint, one thing we see that is frustrating is the impact these kinds of calls have on application processing. Every minute one of our staff people is talking on the telephone with an applicant who is asking about the status of his or her application is time that person is not processing applications. This is why we try to bracket our telephone calls about applications between the hours of 9:00 AM and noon. We are trying to discourage, to the extent we can, concerned family and friends from calling the office about applications. First, we will not discuss a confidential application with a third party. Second, this load hinders our efficiency in turning around applications more quickly.

We occasionally encounter applicants who make premature employment commitments. In some cases, these applicants actually are put on a payroll before they are licensed. If these applicants have a malpractice, discipline, or drug and alcohol history, it takes longer to evaluate them, and we have seen cases where they have been terminated because they did not have their licenses when they thought they would. *The best way to avoid this problem is not to make premature employment commitments.* The minority of applicants who make such commitments are not accelerated ahead of and at the expense of the majority of applicants who have allowed the Board reasonable time to process their applications.

The best advice we can give any applicant, whether applying here or to any other licensing

board, is to allow the Board an appropriate amount of time, obviating the need for telephone calls. That is the best way to get to the end zone directly. If you have a target date to start work, you need to have a completed application in our office two months earlier—one month cuts it too close. If you have significant malpractice history, board action history, or other such problems, you need to allow even more time. Also, we encourage you to take advantage of alternate mechanisms for dealing with questions about application status. We have several improvements in place or in development to help applicants with this information. We provide a self-addressed postcard with the application pack that you can use as a method to confirm delivery of your application to the Board. This is designed to minimize telephone calls so we can use available staff more efficiently to process applications. We are looking at approaches to posting applicant information on the Web that will protect applicant confidentiality. We will let you know about further developments in this area.

Complaints

The information above deals with areas where we are attempting to minimize telephone calls in the interest of efficiency. This clearly does not apply in the area of complaints. We understand that this is a highly sensitive area. Many people, when they call about a complaint, are dealing with a very sensitive issue: their health care. They do not want to leave a telephone message. *We would encourage people to use the complaint form from the Web site to the extent they feel comfortable doing so.* However, you will find that the complaint component of our voice messaging system is designed to get you to a human being, if you need one, in short order. We understand, for example, if you feel you have been sexually abused, that you do not want to leave a voice mail. This is a very sensitive issue and you may wish to talk to a compassionate person to relay your information. We have a very capable complaint department that is equipped to handle this.

In the spirit of this column, which is designed around helpful hints, we offer you the following: *try to have your facts assembled; including the who, what, when, where, and how of the matter.* I recall one patient who sent us a complaint that, in aggregate, was 20 pages long. It was about a diagnostic procedure, but there were pages and pages addressing the nature of forgiveness, the hands of justice, and the passage of time. Now, we will gladly receive extraneous information, but we need as many factual investigative leads as you can furnish. Who was the physician? What did he or she say or do? When, where,

and how many times? Who were the witnesses? Are there other patients you may know of? Is there any supporting or corroborating material, etc? We are not going to second guess why you are filing a complaint. We understand that these are sensitive cases and some time may have passed since the matter arose. We will do all in our power to help you if we can.

Here are two things to bear in mind concerning complaints. (1)The Board is a quasi-judicial agency. It has to meet a burden of proof in order to substantiate a Board action, and there has to be a violation of law within the Board's jurisdiction. Not every complaint can be successfully prosecuted. For example, if you pay \$200 to a practitioner for a medical procedure and one of your friends paid \$100 for a similar procedure with another doctor, there is probably nothing we can do about that. The medical marketplace is still part of our free market. However, if that physician billed an insurance company \$200 for that same procedure and that procedure was not performed, there is something we can do about that. That activity, if proven, can constitute unprofessional conduct and other violations of the law. (2)If it is taking the Board a very long time to finally advise you as to the outcome of the complaint, there is a good chance that there is a legal process going on with the licensee you are complaining about. Complaints that are investigated and found to be unprosecutable are usually opened, acknowledged to the complainant, investigated, and closed with a closure letter to the complainant within three months. If it has been six months or a year or more since you filed your complaint and you have received an acknowledgment from the Board but have not received a notification of final disposition, there is a good chance the Board is actively engaged, which includes a notice to the licensee of alleged violation, a hearing, and final disposition. This is a legal process and, as is the case in all other states, takes much more time to complete.

Physicians and other health care workers are often positioned to be aware of significant Medical Practice Act violations. *The board has a position statement encouraging appropriate reporting of incompetence, impairment, and unethical conduct.*

Emergency Action

I have described above our system for processing contacts with the Board. We do have mechanisms for branching out of this contact system, particularly the phone messaging system, in cases of emergency or urgency: entering 0 for operator. We encourage you to give the messaging system

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**North Carolina
Medical Board**



1-800-253-9653

Dealing with Bureaucracy

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a chance for non-urgent inquiries; you may actually get to the end zone much more quickly. *However, we are equipped to handle a situation that presents an urgent risk to the public health, safety, and welfare, such as a physician showing up for a shift in a hospital while intoxicated.* You need to punch out of our messaging system and contact me or any of our staff with this information so we can address it immediately. When there is a genuine risk to the public, the Board can conduct emergency meetings by teleconference that can result in summary suspension of a license, provided there is imminent risk to the public health, safety and welfare. It takes very little time to put all of this together. The imminent risk standard is necessarily high because, due to the emergency, the Board is taking action before the licensee has a hearing. The Board issues approximately seven summary suspensions a year. In brokering the thousands of contacts we get each year, these matters rise to the top of the list.

General Information Requests

You may perceive this as bragging, to which I plead guilty. However, we have one of the best Public Affairs Departments in the country. We have staff, at Board direction, dedicated to making consumer information available as readily as possible. This is done because we recognize the importance of health care and the importance of this information to consumers. For example, Board actions as a result of the disciplinary process are actively disseminated. We do not in any way attempt to hold public information close to the vest; instead, we take deliberate steps to make it easy to get. The Web page consolidates access to this information. The Board allocates substantial resources to this public information effort, including the *Forum*. I might add parenthetically that these items are funded in North Carolina, as is the case in almost all other states, entirely with revenue from licensees, not from tax revenue or revenue from other sources.

Conclusion

In closing, I hope this material is perceived as intended, as helpful hints to having satisfactory contacts with the Board when attempting to get information. We all hate automated answering systems. About once a month, I get a message from a physician who is furious about having to go through an automated answering system and when I call that physician back I wind up with an automated answering system. It is a necessary evil, but if we are using these systems

correctly, we enhance, not detract from, our ability to respond as efficiently and as effectively as we can.

Most of us, when we hear the word bureaucracy, infer a negative connotation. Webster's, however, provides some options. Bureaucracy can be either "government characterized by specialization of functions, adherence to fixed rules, and a hierarchy of authority," or "a system of administration marked by officialism, red tape, and proliferation." The good definition comes before the bad one. Licensing boards, when fairly administered, operate on fixed rules. To allow certain applicants to accelerate their application at the expense of others would be chaos. To allow one licensee to be sanctioned and another not for the same violation would be unfair and discriminatory. The handling of 218,580 telephone calls, 2,337 applications for licensure, and 31,583 registration forms each year without specialization of function and fixed rules would be total chaos. We aspire to help you get to the end zone as quickly and efficiently as possible, taking full advantage of new technology. It is a work in progress. We invite your comments. ♦

An Honor and a Privilege

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extremely pleased by the fact that Dr George Barrett, past president of the Board, is president elect of the national Federation of State Medical Boards, recognizing his leadership skills and the Board's role in producing distinguished individuals willing and able to serve at the highest levels. Our position has also been enhanced by the fact that both Ms Meelheim and Mr Watry are leading figures in the Administrators in Medicine, the national organization of state medical board executives.

The Board can be extremely proud of the quality of the work it has turned out, the strong administrative staff it has built, the efficiency of its service in licensing over 30,000 individuals, and the responsive approach it has developed for dealing with public complaints and disciplinary issues.

There have been so many changes in the Board it would be hard to recognize them all, but I would like to mention a few I feel have been significant.

- The availability of Dr Jesse Roberts as medical coordinator for the Board has been a wonderful asset, allowing Board members—both physician and non-physician—to get a broader perspective of medically-oriented complaints.

- The increase of talented staff and the implementation of more effective systems in the Complaint Department give us the ability to resolve most complaints in less than half the time it took only a few years ago.

It is my belief that staffing enhancements such as these are responsible for allowing the Board to do its work on a timely basis.

We at the Board have come to recognize that our responsibility goes beyond licensure and discipline. To be vital, that responsibility must also involve trying to educate both the public and the medical community as to what the Board's function is in the present managed care environment and how we can fulfill that function better. In the process, we hope to build on the rapport we have developed with the health care professionals and the public we serve to ensure that the basic trust that has always been and is so essential a part of the patient/physician relationship is never broken or forgotten as changes evolve in the delivery of health care. I consider North Carolina to have the best community of physicians, physician assistants, and nurse practitioners in the country, and nothing should be allowed to impinge on their ability to provide appropriate medical care to the people of this state.

I have considered it an honor and a privilege to be president of the North Carolina Medical Board. I have appreciated the opportunity afforded me by the other members of the Board. I know that the next president, Wayne VonSeggen, PA-C, of Winston-Salem, will do an excellent job and serve the Board with professionalism, distinction, and honor. ♦

Women Now Outnumber Men in Pharmacy

According to the April issue of the *North Carolina Board of Pharmacy News*, for the first time in North Carolina's history, as of January 1999, the majority of active pharmacists are women. Board statistics reveal that, both full-time and part-time, there are 3,227 female pharmacists active in this state and 3,223 male. These figures reflect recent pharmacy school graduation statistics, which in North Carolina indicate that women are about 70 percent of the graduates.

Desmoteriac Medicine: A.K.A., Correctional Health Care

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North Carolina Department of Correction's Division of Prisons



Dr. Pohlman

At mid-year 1997, more than 1.7 million people, or one of every 155 U.S. residents, were in either jail or prison. At year-end 1997, one of every 117 males and one of every 1,852 females were sentenced prisoners under state or

federal criminal jurisdiction.¹ Fifteen million arrests are made annually² and over ten million individuals are released from detention each year. Approximately two-thirds of incarcerated individuals are in state and federal facilities, and the remaining third are in local, generally short-term stay jails. The incarcerated population cannot and must not be considered a small, separate population with little relevance to the outside community.

When offenders are sentenced to prison, the state becomes responsible for providing them health care. Desmoteriac medicine is the practice of medicine where the patient population is incarcerated or in "bonds." The term "desmoteriac" originates in the Greek root *desmos*, meaning band, bond, or ligament.

Historical Trends

In the 1950s and 60s, health care needs of the incarcerated were primarily acute injuries and illnesses consistent with health care needs of a younger, essentially healthy population. Closure of many public mental institutions in the 1970s led to the incarceration of many mentally ill for charges stemming from illness-induced behaviors. In addition, the National Drug Control Strategy, announced in 1989, called for mandatory minimum sentences for drug crimes. By 1995, the impact of the strategy had dramatically altered the composition of the prison inmate population: the number of inmates in state prisons for drug offenses as their most serious crime had increased 478% over the 8.6% reported in 1985³. More recently, mandatory sentencing and longer prison sentences have contributed to the increasing trend of older inmates with

chronic diseases: hypertension, coronary artery disease, chronic obstructive pulmonary disease, diabetes, hepatitis, HIV, and others.

The impact of these trends in the North Carolina prison system has caused our state prison population to nearly double in 10 years; from approximately 17,000 in 1989 to nearly 33,000 in 1999. Chronic medical conditions, mental disorders, disease states associated with drug use, and constant advances in the treatment of HIV and new therapies for hepatitis C have created significant challenges in the provision of health care to this unique population.

Constitutional and Statutory Obligations

The Health Services Section of the North Carolina Department of Correction (DOC) is mandated to provide inmate medical services that meet community standards. Our constitutional obligation, grounded in the Eighth Amendment, and the statutory requirement, GS 135-40.7(5), are best described in one of the landmark court decisions impacting correctional health care, *Estelle vs Gabel*: "...deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain" in violation of the 8th Amendment. This requirement and the North Carolina statutory requirement (GS 135-40.7(5)) charge DOC Health Services to provide inmates access to quality care provided by competent health care professionals.

NC DOC Health Services Mission

The North Carolina DOC Health Services mission is to meet our constitutional and statutory obligation in a fiscally responsible manner by:

- viewing correctional facilities as public health stations that significantly impact the health status of the larger community;
- managing the care in order to improve the health status of the inmate and non-inmate population in order to get best value for the total tax dollars spent;
- continually asking five questions:
 - Does the care meet community standards?
 - Is the care good medicine?
 - Is the care appropriate for the inmate?
 - Is the care provided good for the public health?
 - Have we managed the care in a way

that does not sacrifice quality and community standards?

Primary Care Driven System

Currently, inmate health care includes physical, dental, and mental health services that inmates receive on admission to the Department of Corrections and throughout their incarceration. When they enter the system through one of the Department's processing centers, inmates receive a number of health care examinations conducted by health services staff. Inmates receive a physical examination, including any needed laboratory tests and X-rays. They receive a visual dental exam and, when determined necessary by a dentist, X-rays and treatment to correct existing problems. Additionally, inmates receive a mental health screening, which includes testing and an interview by mental health staff to determine their current psychological functioning level. As a result of these examinations, health services staff assigns each inmate a medical classification status that indicates his or her physical and mental capability for institutional and work assignments. Inmates who have been identified as having a chronic medical condition, such as diabetes, asthma, hypertension, seizures, and/or HIV, are scheduled for routine follow-up visits

at intervals not to exceed 90 days once they reach their assigned institutions.

At each of our major correctional institutions, on-site health care staff provides primary health care services to inmates. Health care staff are available or on call 24 hours per day. Inmates requiring consultations with specialists or tertiary care not readily available within the Department are transported to community facilities for treatment. When necessary, emergency care is provided by the closest hospital emergency room.

As in the rest of society, the delivery of health services in prisons is generally based on a patient requesting services via the "sick call" process, describing symptoms, and following the doctor's instructions. Clearly, many patients in the "free world" seek health services in an attempt to obtain secondary

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Desmoteric Medicine

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gain (ie, excused absences from work, disability benefits, etc). A recent study by the Florida Office of Program Policy Analysis and Government Accountability highlighted how secondary gain is magnified in the incarcerated population: "In prison, health services is a primary means by which inmates can achieve secondary gains, such as avoiding work, relieving boredom, talking to nurses and other medical staff, or being transported out of the institution to a community hospital or another institution. Inmates may describe false or exaggerated symptoms in an attempt to achieve secondary gain."⁴ The examples cited in the Florida study are not uncommon in North Carolina.

- An inmate who complains of foot pain may be accurately describing a medical problem or may simply be trying to obtain a medical exemption that would allow him to wear softer shoes than the Department's regulation footwear.
- An inmate who visits sick call complaining of lower back pain may be feigning symptoms in hopes of obtaining an assignment to a lower rather than an upper bunk.
- An inmate who declares a mental health emergency, such as self-injurious behavior, may be seeking to be moved to a crisis stabilization unit or to a different institution for some other gain, such as location, interaction with staff or other inmates, etc.

Trained nursing staff triage patients for sick call, assess and treat patients according to written nursing protocols, and refer patients to physician extenders and physicians as appropriate. The process is similar to that of a typical primary care practice.

The North Carolina Correctional Health Care System

In the last few years, our system has transformed from a provider of prison health services to a health care system that provides services in the correctional environment. Today, we function as a managed care organization with expenditures of approximately \$103M. The Health Services Division of the NC Department of Corrections is a managed care organization with:

- approximately 33,000 covered lives,
- 20,000+ new admissions per year,
- 3 inpatient facilities,
- 84 ambulatory/primary care centers,
- aggressive utilization management,
- aggressive claims management.

Despite population increases and a variety

of factors that tend to increase the cost of inmate health care, inmate health care costs in North Carolina have grown at a slower rate than overall medical costs and at a slower rate than medical care inflation. The Department's cost containment efforts have been effective in reducing costs and include:

- establishing an inmate co-payment system, whereby inmates pay \$3 for inmate-initiated, non-emergency visits or \$5 for an inmate-declared medical emergency;
- establishing a utilization review system that requires pre-certification and authorization for off-site specialty consults, outpatient and inpatient services;
- establishing managed care contracts with community hospitals and specialists;
- utilizing telemedicine to provide a video link between inmates and medical specialists;
- monitoring claims from outside providers for overcharges, incorrect coding, and contractual reimbursement compliance issues.

Career Opportunities in Desmoteric Medicine

Good medicine is good medicine, wherever it is practiced. In a security/custody environment, correctional officers have an important role in the delivery of healthcare: control of patient flow, transportation of patients, records, observations on behavior, etc. In addition, the correctional officer often has knowledge of specific inmate behaviors and activities that are invaluable to the licensed health care professional, ie, eating patterns and preferences, medication adherence issues, recreational activities, etc. Desmoteric medicine is a true multi-disciplinary team effort that provides appropriate, medically necessary care for our patients.

Work with inmate patients in this special environment is challenging, interesting, and provides clinical experiences that are not often encountered in the "free world." For the physician or physician extender with the interest and aptitude to work collaboratively and cooperatively in a team environment on challenging clinical issues, desmoteric medicine offers a challenging and satisfying career opportunity.

"In the last few years, our system has transformed from a provider of prison health services to a health care system that provides services in the correctional environment."

Notes

1. U.S. Department of Justice. *Bureau of Justice Statistics Bulletin: Prisoners in 1997*, August 1998.
2. CDC. Assessment of Sexually Transmitted Diseases Services in City and County Jails—United States, 1997. *MMWR*, 1997, 47:429-31.
3. *Bureau of Justice Statistics, Correctional Populations in the United States, 1996*. U.S. Department of Justice, Office of Justice Programs. Washington, DC.
4. The Florida Legislature, Office of Program Policy Analysis and Government Accountability. *Review of Inmate Health Services Within the Department of Corrections*. Report No 96-2. ♦

Post-Dated Prescriptions Not Permitted

Donald Pittman

Field Supervisor, NCMB Investigative Department

From time to time, Board investigators discover prescriptions issued for controlled substances that have been "post-dated." The authorizing physician, for various reasons, will issue two or more prescriptions to a single patient for the same medication, record on one the date the prescription was written and on the other(s) the date(s) in the future. According to the Code of Federal Regulations, Part 1306.05(a), all prescriptions for controlled substances *shall be dated as of*, and signed on, *the day when issued* and shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and registration number of the practitioner. A prescription for a controlled substance with a recorded date other than the day it was issued would not be in compliance with this federal regulation.

Whatever the reason a physician may have for issuing multiple prescriptions for the same medication to one patient during a single office visit, there is an *acceptable approach* to accomplishing this. A physician may issue two or more prescriptions for the same medication on the same day by dating them *all* the day they are issued and writing "do not fill until (future date[s] that medication may be dispensed)" on the one(s) to be filled at a later time.

Wayne W. VonSeggen, PA-C, of Winston-Salem, Elected President of North Carolina Medical Board: First Physician Assistant to Hold The Post

At its regular meeting in July, the North Carolina Medical Board elected its officers for the next year. They will take office on November 1, 1999, and serve until October 31, 2000.

Wayne W. VonSeggen, PA-C, New NCMB President

Wayne W. VonSeggen, PA-C, of



Mr VonSeggen

Winston-Salem, will assume the post of president of the North Carolina Medical Board on November 1, succeeding Mr Paul Saperstein, of Greensboro, in that position. Mr VonSeggen is the first physician assistant to be chosen

president of the Board. He has served as vice president of the Board over the past year.

Mr VonSeggen, a native of Iowa, has been a physician assistant for over 22 years and currently works with Dr George Franck at the Employee Health Center at Wake Forest University Baptist Medical Center in Winston-Salem. He received his BA degree in chemistry and zoology from Olivet Nazarene University in Illinois, with graduate work in anatomy at the University of Iowa, and completed the Physician Assistant Program at Bowman Gray School of Medicine of Wake Forest University. He is a fellow member of the American Academy of Physician Assistants, a charter member of the North Carolina Academy of Physician Assistants, and an associate member of the North Carolina Medical Society, participating with the Bioethics Committee.

Mr VonSeggen has served as president of the North Carolina Academy of Physician Assistants, has coauthored the results of three state-wide surveys of the PA profession, and plays an active role in several professional organizations. He was named to the Board in 1994 and has acted as chair of the PA Committee, nominating members of the PA Advisory Committee to the Board. He has been a member of several other key Board committees, including the Licensing, Investigations, EMS, and Scope of Practice Committees.

Elizabeth P. Kanof, MD, Vice President

Also on November 1, Elizabeth P.



Dr Kanof

Kanof, MD, of Raleigh, will become vice president of the North Carolina Medical Board, replacing Mr VonSeggen. Dr Kanof was appointed to the Board in 1996 and served as secretary-treasurer over the past year.

Dr Kanof, a native of New York, received her BA from Mount Holyoke College and her MD from New York University. She did an internship at Kings County Hospital Center and residencies in dermatology at New York University-Bellevue Medical Center and Duke University Medical Center. She is a fellow of the American Academy of Dermatology and a diplomate of the American Board of Dermatology. She holds appointments as assistant clinical professor of dermatology at the Duke University School of Medicine and as adjunct clinical professor of dermatology at the University of North Carolina School of Medicine.

Very active in organized medicine, Dr Kanof served as president of the Wake County Medical Society in 1984 and of the North Carolina Medical Society in 1994. She has served on or chaired numerous Medical Society committees and currently serves as a Medical Society delegate to the American Medical Association. Over the years, she has also been a participant in a wide range of community and charitable groups.

She has published several articles and, in 1996, was coauthor of "Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence," published in the *Annals of Emergency Medicine*.

Dr Kanof has served on the Board's Malpractice, Physician Assistant, Physicians Health Program, and Liaison Committees, and has been chair of its Complaints, Scope of Practice, and Alternative Medicine Committees.

Walter J. Pories, MD, Secretary- Treasurer

Walter J. Pories, MD, of Greenville, will



Dr Pories

take office as the Board's new secretary-treasurer on November 1, replacing Dr Kanof. A native of Germany, Dr Pories is professor of surgery and biochemistry at the East Carolina University School of Medicine. He is also

a clinical professor of surgery at the Uniformed Services University of Health Sciences. He received his BA at Wesleyan University, Middletown, Connecticut, and his MD with honors from the University of Rochester School of Medicine and Dentistry. His postgraduate study included an internship at Strong Memorial Hospital of the University of Rochester; a part-time fellowship at the Centre du Cancer of the Universite de Nancy, France; a graduate research fellowship in biochemistry at the University of Rochester; and a residency in general and thoracic surgery at Strong Memorial Hospital. He is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He was appointed to the North Carolina Medical Board in 1997.

Frequently honored for his work as a surgeon and teacher, Dr Pories is a past governor of the American College of Surgeons and has served as president of the North Carolina Chapter of the American College of Surgeons, the North Carolina Surgical Association, the Eastern Carolina Health Organization, Hospice of Greenville, and the Association of Program Directors in Surgery. Active on a large number of professional boards and committees, he is also the author/coauthor of 47 book chapters, 7 books, and over 250 medical articles dealing primarily with the metabolism of trace elements, diabetes, and surgical education. He has also been involved in the making of four educational films.

Dr Pories is a retired colonel of the U.S. Army Reserves. He has published over 50 cartoons and is a talented artist. ♦



Why Give Due Process?

Deciding whether to deny an applicant a license and considering whether to take one away are among the most difficult and wrenching decisions the North Carolina Medical Board must make. The Board neither relishes these duties nor shrinks from them. Usually, a person appearing before the Board has invested a lifetime to reach professional goals. Society, likewise, has a considerable stake: its own investment in the person's education and training and its need for protection from the occasional unscrupulous, incompetent, or impaired medical professional. Because so much is at stake, emotions tend to run high.

"No one shall be deprived of life, liberty, or property, without due process of law."

To help ensure that these decisions are carefully and fairly made, the Board must follow certain law and rules, commonly referred to as "due process" after the language of the Fifth Amendment to the U.S. Constitution, which states that no one shall "be deprived of life, liberty, or property, without due process of law." The North Carolina Constitution, in its "law of the land" clause contains a very similar idea. Basically, the concept is that a state (acting in this case through a medical board) must use due process before depriving a person of a property right (in this case a license or other approval to practice). The question, then, is, What process is due a person in these circumstances?

What Process Is Due?

It surprises some that the Board's power is not absolute on such matters. The constitutions establish a minimum, the fundamentals of which, generally speaking, include having notice that the matter is being considered and an opportunity to be heard. Statutes passed by the General Assembly, and to some extent by Congress, provide more, governing the reasons the Board may act, the procedures it must follow, and the actions it may take. While few Board decisions are ever disturbed, its actions are subject to review by the courts.

On What May the Board Act?

Statutes (and rules for physician assistants, nurse practitioners, and emergency medical technicians) set forth the reasons the Board may deny a license or take one away. About 20 reasons are given. Many are fairly obvious: unethical or unprofessional conduct,

Notes on Due Process

James A. Wilson, JD
Director, NCMB Legal Department

incompetence, and being impaired. Others are less so, for example, not paying child support. Some of these are written in broad and general terms, allowing the Board to enforce professional standards within the common understanding of those in practice. Others are fairly specific, for example, failure to register. Only the one requiring continuing medical education explicitly authorizes the Board to make rules outlining its contours. In sum, the Board has broad power to act, but unless one of these reasons in the statutes or rules applies, the Board's hands are tied. As an example, without more to act on, conviction of a misdemeanor is not necessarily grounds for discipline.

What Procedures Must the Board Use?

In its investigations

Statutes set forth the procedures the Board must use. It is given broad but not unlimited powers in investigating its cases. For example, the Board can obtain patient records without obtaining a court order (as is usually required in court cases), but it does not have the power to search without consent (as in a search warrant) nor does it make arrests.

In its hearings

Proceedings before the Board are much like civil cases in court. Statutes govern how the Board begins a case, who will hear the case, and where the case will be heard. Statutes govern the discovery process by which information is exchanged in the case, what portions of the proceeding and documents are public, and what evidence is admissible. Statutes give the Board's opponents rights to appear personally and with a lawyer, to cross examine witnesses, to present evidence, to subpoena witnesses, and to make arguments. Statutes give the presiding officer judge-like powers and require the Board to act somewhat like a jury. Statutes govern the right to appeal a Board decision, which is fairly similar to appeals in civil cases, going through the courts to ensure the Board has acted lawfully, that its decisions are supported by the evidence, and that it has not acted arbitrarily or capriciously.

What May the Board Do?

Statutes govern the actions the Board may take, giving it the power to deny an application, annul, revoke, suspend, or limit a license. Under limited circumstances, the Board may order restitution. It may also stay its actions or restore a license on condi-



tions. In emergencies, the Board may suspend or summarily suspend a license pending the outcome of a case, but it must promptly begin and decide the case after doing so. It does not have the authority to do other things, such as fine or imprison.

Can the Process Be Abbreviated?

Sometimes hearings before the Board are conducted elaborately, using all the procedures set out above in all their detail. Usually, considerable effort is applied to narrowing the issues to those truly in dispute, and, with the consent of the Board and the affected person, the unnecessary procedures can be discarded. Put another way, the process is designed not only for fairness but also for efficiency.

Consent Orders

At any point in the process, from before charges are brought to after the hearing is held, the Board and the affected person can agree to a resolution of the matter. Public policy in North Carolina encourages the Board, though the law does not require it, to attempt resolution of cases through informal means. When an accord can be reached, the law expressly permits an agreed disposition of the matter.

The usual mechanism is a Consent Order. Consent Orders are both orders of the Board and agreements between the Board and the affected person. Consent Orders typically begin by identifying the affected person and setting forth the areas of concern to be addressed. Next, Consent Orders recite the obligations of the Board and the affected person, for example, the person's license status and the conditions on which the continuation of that status depend. Consent Orders contain an enforcement mechanism, usually that a failure to abide by the Consent Order will constitute grounds for the Board to act, even if the law would not otherwise give the Board such power.

"Because the Board's decisions can end a career, it is important they be made carefully and deliberately."

How Much of This Is Public?

By statute, the Board's licensing and investigative information is not public, unless and until it is used in a case before the Board. Also by statute, once the Board

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Notes on Due Process

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begins a case, much becomes public. The Notice of Charges is public, as is any response to it. The hearings themselves are open to the public, and the things admitted into evidence and the transcripts of testimony are public. Though the Board's deliberations are closed, its final written decisions are public. Appeals of Board decisions are public. Consent Orders are public. However, by statute, the Board will protect the identity of patients who do not consent otherwise.

Conclusion

Contrary, perhaps, to the impression of some, the Board is not set at large to "make things right." It can act only on the grounds set forth in the law, using only the procedures and taking only the actions established by law.

Obviously, no system can ensure perfect decisions, and because the Board's decisions can end a career, it is important they be made carefully and deliberately. The procedures outlined here are designed to guide the Board to fair and just consideration of each case it addresses.

Notice to Physician Assistants: Provisional Approval No Longer Available

The North Carolina Medical Board wants you to be aware that provisional approval is no longer available for physician assistants. (Provisional approval is not to be confused with a temporary license, which is the type of license a PA receives before taking or passing the examination of the NCCPA.) Temporary and full license numbers will be assigned once each month during the regularly scheduled meetings of the Board. This approach is required because there is no provision in the statutes of North Carolina for staff approval of a license application; it must be voted on by the Board. An applicant can expect to get her or his license number in writing within seven business days following the last day of the Board meeting at which the application is approved. Application deadlines are printed in each issue of the *Forum*.

NCMB Adopts Position Statement on Laser Surgery

At its meeting in July, the North Carolina Medical Board adopted a position statement on laser surgery. It appears below.

The principles of professionalism and performance expressed in the position statements of the North Carolina Medical Board apply to all persons licensed and/or approved by the Board to render medical care at any level. (The words "physician" and "doctor" as used in the position statements of the Board refer to persons who are MDs or DOs licensed to practice medicine and surgery in North Carolina.)

LASER SURGERY

It is the position of the North Carolina Medical Board that the revision, destruction, incision, or other structural alteration of human tissue using laser technology is surgery.* Laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by this state to perform surgical services.

Licensees should use only devices approved by the U.S. Food and Drug Administration unless functioning under protocols approved by institutional review boards. As with all new procedures, it is the licensee's responsibility to obtain adequate training and to make documentation of this training available to the North Carolina Medical Board on request.

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by a licensed practitioner with appropriate medical training functioning under the supervision, preferably on-site, of a physician who bears responsibility for those procedures.

*Definition of surgery as adopted by the NCMB, November 1998:

Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up. ♦

(Adopted July 1999)

Ms Erin Gough Named New Physician Extender Coordinator



Ms Gough

Ms Erin Gough is the new Physician Extender Coordinator for the Licensing Department of the North Carolina Medical Board. She succeeds Ms Teresa Wrenn.

Ms Gough is primarily responsible for processing physician assistant applications and intent to practice applications. Her duties include preparing PA materials for review by the Board and staffing Nurse Practitioner, Physician Assistant, and Midwifery Committee meetings. She also assigns PA license numbers and is authorized to make written and verbal verifications of PA licenses and NP practitioner approvals.

She is available to answer telephone inquiries regarding application requests, application status, verifications, and rules applicable to PAs and NPs on any weekday from 2:30 to 5:00 PM. She may be reached at (800) 253-9653, extension 233, or (919) 326-1100, extension 233.

Mr James Campbell continues to handle NP applications (initial and subsequent). Questions about these may be directed to him on any weekday from 2:30 to 5:00 PM. He may be reached at (800) 253-9653, extension 250, or (919) 326-1100, extension 250.

The NCMB's Web site features a useful description of the Licensing Department and now offers the PA Intent To Practice Form. The rules and the Medical Practice Act may also be downloaded from the site. The address is www.docboard.org/nc. ♦

Hurricane Floyd

Andrew W. Watry
Executive Director, NCMB

Hurricane Floyd and its accompanying deluge of rain presented a disaster of unprecedented proportions for North Carolina—particularly the eastern portion of our state. The problems its aftermath presents our licensing system are pale by comparison with the misery and suffering of thousands of our citizens. However, it did affect our licensing system and we have had serious questions about licensing issues. In an effort to be helpful, we offer the following suggestions that may be of benefit to those adversely affected.

Medical Records

As you know, the Board has a position statement on medical records. This position statement, along with the rules and laws governing the practice of medicine, can be found at our Web site at www.docboard.org/nc. Several physicians had their offices flooded by Floyd and did not have enough time to salvage their medical records, which are now so much mush.

We have received questions about what would happen if, in the future, one of these physicians was called on to produce a patient chart that had been destroyed by flood waters? In that regard, we want you to know that one of the reasons this state and all other states have medical boards is to provide a group of reasonable, responsible board members, fellow citizens, to apply prudent judgement on public protection issues. The North Carolina Medical Board is among the most reasonable and prudent you will find anywhere in the country. You can read between the lines of the Board's position statements the public policies that are the foundation for those statements. The Board is attempting to ensure that there is continuity of patient care, that patients have access to their medical records, and that medical records are appropriately documented so they are useful instruments in managing patient care. That being said, if an issue presents itself one, two, or five years from now where a medical record is requested to resolve a patient complaint or similar issue, you can expect the Board to be reasonable if the physician's office or record storage area was ravaged by the floods accompanying Floyd in September 1999. It may simply be impossible for that physician to produce a good medical record because of the flood damage.

We have suggested to those who have

asked that they should apply the same principles to rebuilding badly damaged or destroyed records as they would to triaging patients. That is, they should identify the patients with the most urgent needs, including those requiring routine prescriptions, and try to rebuild those records first based on memory and any other sources available. We have also suggested placing a note in each patient's file stating that certain records were not recoverable due to flood damage and the basis on which a reasonable, good faith effort was made to restore such records. This document itself will serve as part of the medical record to explain the absence of critical documentation. (We recognize that, in some instances, it may not be possible or reasonable to attempt the rebuilding of a particular record.)

In summary, a licensee can expect the Board to be reasonable in future issues when original and complete patient records cannot be produced as a result of Floyd's devastation. The Board simply expects licensees to make reasonable efforts to restore those records, where appropriate, consistent with the public policy that governs the Board's actions.

Volunteerism

Balancing the negative effects of this tragedy are the significant volunteer efforts to help people recover. There is considerable volunteerism occurring in the medical community. We have received the inevitable licensing question as a result. This state, as is the case in most other states, has an emergency plan whereby the Governor can take emergency action to relax licensing statutes where appropriate. Exercising this authority in the case of Floyd was not necessary.

Licensing statutes exist for a good reason: public protection. In a disaster such as North Carolina has suffered, the public needs to be protected from fleecing by price-gouging, shoddy contractors, and others who might take advantage of such a situation. Medicine is no exception. There are over 5,000 physicians disciplined in this country each year for rather significant violations of public trust. There are many thousands more people in this country who were trained as physicians but who have not demonstrated the minimum competencies required by the licensing system, such as passing a licensing exam, completing appropriate post-graduate training, and passing credential checks involving criminal history, action in other states, malpractice history, etc.

There is significant volunteerism by appropriately licensed and credentialed physicians and, frankly, no need to compound this disaster by exposing our citizens to medical personnel who have not been appropriately credentialed. The North Carolina Medical Society has risen to the task of coordinating volunteerism for this critical situation from the large pool of physicians who hold a North Carolina license.

Any physician who would like to put his or her name on a list of volunteers to help in future emergencies should write or telephone the North Carolina Medical Society: 222 North Person Street, Raleigh, NC 27601; (919) 833-3836.

Immunization

There is an increased need for immunizations due to the ravages of Floyd. Fortunately, this state has an effective approach to making immunizations available to the public at times like this. They are available through the health departments and from a variety of authorized health care providers.

Clearly, immunizations should be given only by those qualified and authorized to do so. A small percentage of people have reactions to immunizations that require appropriate medical treatment. There are other issues, such as the handling of hypodermic needles, that require appropriate training to prevent the spread of infection and viruses such as HIV and hepatitis. Immunizations require appropriate medical control, which means a prescription from an authorized practitioner and an appropriate protocol for delegation of administration to other practitioners, including appropriate management of the serum and the hypodermic needles. You do not want serum that is out of date or has been improperly stored or needles that may transmit infection.

In short, there is a good reason for the protections afforded by your state licensing system, including the licensing or approval of physicians, pharmacists, physician assistants, advanced practice nurses, nurses, paramedics, and other health practitioners involved in this recovery effort. Any waiving of the requirements would only compound risks for those already suffering as a result of this disaster. ♦

Don't Underestimate the Importance of Chaperones

Naomi M. Tsujimura, RN, CCRN

Claims Department, Medical Mutual Insurance Company of North Carolina



Ms Tsujimura

The relationship between a physician and a patient is based on trust and mutual confidence. The North Carolina Medical Board identifies multiple elements that are necessary for maintaining a patient's trust. (See the NCMB's position statement: The Physician-Patient Relationship.) Among the elements identified are respect for a patient's autonomy, the assurance of confidentiality, and adequate communication between physician and patient. During the course of the physician-patient relationship, it is very likely that a physical examination, which includes deliberate examination and touching of the patient by the health care provider, will occur.

Reassuring the Patient, Protecting the Physician

Chaperones have long been used for gynecologic examinations and procedures. The third party serves not only to provide reassurance to the patient and to assist the physician, but also to protect the physician against unfounded accusations of inappropriate behavior.

"Despite their rarity, allegations of sexual misconduct have been brought against physicians and dentists practicing in diverse fields."

Allegations that health care providers have committed sexual improprieties against patients are infrequent. Despite their rarity, allegations of sexual misconduct have been brought against physicians and dentists practicing in such diverse fields as family practice, psychiatry, anesthesiology, general dentistry, and endodontics. When allegations of sexual improprieties are made, the accused faces the devastating aftermath of emotional turmoil, damage to professional credibility, possible criminal charges, and costly civil actions.

How are health care providers using chaperones? Studies reflect that the use of chaperones during female genital examination varies by sex of the health care provider.

One study of family physicians noted that 79.4% of male physicians and 31.9% of female physicians surveyed used chaperones during female genital examinations. The same study

noted the rate of chaperone use during male genital examination was 1.4% for male physicians and 14.4% for female physicians.¹ Another study of primary care physicians reported higher chaperone use during female genital examination: 96.9% for male physicians and 64.0% for female physicians.²

The study of chaperone use has now expanded to include health care providers who care for patients whose mental status may be altered by the use of sedatives, hypnotics, anxiolytics, or analgesics, or by recovery from anesthesia. A patient awakening from anesthesia may misinterpret a touch or even imagine a sexual advance that did not happen.

Many dentists who use sedation during procedures have made having a third party in the room a standard operating procedure. Anesthesiologists are usually providing anesthesia care in the presence of a room full of their peers. However, sexual assaults have occurred in pre-operative holding areas and recovery rooms. In a California case, an anesthesiologist drew the curtains around the stretchers of several female patients in order to conceal his assaults.³

What Can You Do?

What can you do as a health care provider to protect yourself against unfounded accusations of sexual misconduct? The North Carolina Medical Board's current position statement on the subject, Guidelines for Avoiding Misunderstandings During Physical Examinations, states that:

Whatever the sex of the patient, a third party should be readily available at all times during a physical examination, and it is advisable that a third party be present when the physician performs an examination of the breast(s), genitalia,

or rectum. When appropriate or when requested by the patient, the physician should have a third party present throughout the examination or at any given point during the examination.

Current risk management recommendations from Medical Mutual advise the use of a chaperone for all physicians conducting any type of physical examination in which removal of clothing is involved. The presence of a chaperone is *strongly recommended* if a physician and patient are of different genders and an examination involves clothing removal. It should be noted that these recommendations apply to patients of all age groups.

As stated previously, chaperones have been most frequently used during female genital examinations.

"A chaperone is strongly recommended if a physician and patient are of different genders and an examination involves clothing removal."

the prevailing litigious climate, chaperones should be considered for male genital examinations. As a physician, the issue of a chaperoned examination should be addressed with the patient *prior* to the examination. Should a patient refuse a chaperone,

this refusal should be documented and initialed by the patient.

Because physicians are continually asked to "do more with less," your practice may view the use of chaperones as a poor use of resources. The use of chaperones does require staff coordination and may result in increased time between patient examinations. However, the cost of being falsely accused of sexual misconduct in a victim-oriented, tabloid-saturated society cannot be underestimated.

Notes

1. Gilchrist, Gillanders, Gemmel: Chaperoning Practices of Ohio Family Physicians. *Family Medicine*, July 1992; Vol 24, No 5: 386-389.
2. Renfro, Replogle: Chaperone Use in Primary Care. *Family Medicine*, March-April 1991; Vol 23, No 3: 231-233.
3. *Anesthesia Malpractice Prevention*. April 1996; Vol 1, No 4: 25-27.

Reprinted in edited form from Medical Mutual's quarterly *MedNotes*, Summer 1999. ♦

Electronic Distribution to Be Used for Some Forums, Bimonthly Board Action Reports, Immediate Action Notices

Forum

Beginning in 2000, the *Forum* will be available to commercial organizations and a number of other groups and individuals only via the Internet. The North Carolina Medical Board's Web site (www.docboard.org/nc) has been presenting the *Forum*, exactly as it appears in its printed form, since late 1998. To access it only requires the Adobe Acrobat Reader, which can be downloaded free at www.adobe.com, and the Board's Web site provides a quick link to the Adobe site. Using the Adobe Acrobat Reader, the *Forum* can be easily read on screen and readily printed out. This has been the general public's major access to the *Forum* for the past year. (Should you have trouble with this process, please contact Jennifer Deyton of the Board's Public Affairs Department. She can be reached by telephone at 1-919-326-1100, ext 271, or by e-mail at public.affairs@ncmedboard.org.)

We find this approach an effective way of dealing with the constantly growing demand for the *Forum* on the part of a very wide spectrum of readers. From a practical point of view, only so many copies of the *Forum* can be published and mailed each quarter. However, this electronic system allows those who have an interest in the *Forum*, the diverse articles and the data it presents, to receive it if they have access to the Internet in home, office, or library. Therefore, should you not receive the first number of the *Forum* for 2000 by early April 2000, check the Internet. The new number will be there or a notice will be posted telling you when to expect its appearance.

Bimonthly Board Action Reports and Immediate Action Notices

For almost five years, the North Carolina Medical Board has been sending a Bimonthly Board Action Report, listing all its public actions relating to physicians, physician assistants, and nurse practitioners, to hospitals, medical groups, and the news media. It has also issued Immediate Action Notices for actions involving annulments, revocations, suspensions, summary suspensions, and license surrenders. These notices go out as soon as the

actions occur and make the information available at once, not delaying it until the next bimonthly release. Due to cost constraints, the Board has focused over these years on sending these materials only into those counties in which the involved physicians, PAs, or NPs actually practiced and to relevant state agencies. As with the *Forum*, which reprints the reports for statewide circulation, the Bimonthly Board Action Reports and the Immediate Action Notices have been appearing on the Board's Web site (www.docboard.org/nc) since 1998. In fact, we are now posting a full year's worth of the bimonthly reports, allowing the Web user to go back over the year's activity. Anyone with access to the Internet can easily review these reports and notices: the public, hospitals, medical groups, the media, other state agencies, other states, etc.

We want all the state's hospitals, medical groups, news media, and relevant organizations to know that we would like to notify them by e-mail each time a new report or notice has been posted. This notification system would ensure quick statewide distribution of the material, not limited simply to the counties in which the involved practitioners may practice. Any hospital, medical group, newspaper or journal, television or radio station, or interested organization that makes its e-mail address available to us in writing or by e-mail will be made a part of this notification system. That will make it unnecessary for us to mail a printed copy of the particular Bimonthly Board Action Report or Immediate Action Notice to that institution, organization, or person, saving time and costs on both sides.

If you wish to participate in this system, please send the appropriate e-mail address, along with your name or the name of the responsible person, and the name and address of your institution, organization, or other affiliation, to: Jennifer Deyton, Public Affairs Department, North Carolina Medical Board, PO Box 20007, Raleigh, NC 27619; or e-mail the same information to Ms Deyton at public.affairs@ncmedboard.org. ♦

AHCPR and Other Guidelines on Pain Available

Among its many other activities over the past decade, the Agency for Health Care Policy and Research (AHCPR) of the U.S. Public Health Service has facilitated development of clinical practice guidelines on a variety of topics. Three of these, published from 1992 to 1995, deal with the management of pain. They include *Acute Pain Management: Operative or Medical Procedures and Trauma*; *Management of Cancer Pain*; and *Acute Low Back Problems in Adults*.

Several versions of each guideline are available. The "Clinical Practice Guideline" presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references. "The Quick Reference Guide for Clinicians" is a distilled version of the "Clinical Practice Guideline," with summary points for ready reference on a day-to-day basis. "The Consumer Version (or Patient Guide)," available in English and Spanish, is an information booklet for the general public to increase patient knowledge and involvement in health care decision making.

To order single copies of these (or any) AHCPR guideline publications or to obtain further information, call the AHCPR Publications Clearinghouse toll-free at 800-358-9295 or write to: AHCPR Publications Clearinghouse, PO Box 8547, Silver Spring, MD 20907.

Also available is the fourth edition of *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain* (1999) from the American Pain Society, 4700 West Lake Avenue, Glenview, Illinois 60025-1485. The APS' Web site address is <http://www.ampainsoc.org/>.

The World Health Organization has several titles dealing with the relief of cancer pain and palliative care. These include the second edition of *Cancer Pain Relief with a Guide to Opioid Availability* (1996), *Cancer Pain Relief and Palliative Care in Children* (1998), and *Symptom Relief in Terminal Illness* (1998). For further information on these publications, contact Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland. ♦

North Carolina Medical Board

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North Carolina Physician Demographics: 1979-1998

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Thomas C. Ricketts, PhD, MPH, Deputy Director, Sheps Center for Health Services Research, UNC, Chapel Hill - Director, Rural Health Research Program.

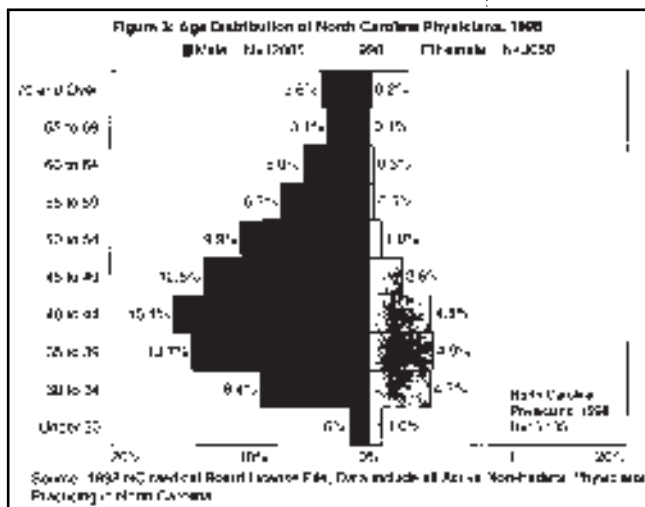
The demographic structure of North Carolina's physician work force has undergone significant changes over the last 20 years. The proportion of women physicians is increasing every year, and the age structure of the state's physicians is also changing. Physician demographic characteristics are not homogenous across the state, as physicians in rural counties are older on average and there are proportionally fewer rural women physicians than urban.

physicians 55 and over had declined to 22.1%, while the proportion of physicians under 35 had risen over 40% to 22.8%. The proportion of female physicians in the state had more than doubled to 12.5%, as nearly one quarter (24.2%) of the physicians under 35 years of age were women.

The percentage of women physicians practicing in the state continued to rise into 1998, when more than one in five physicians (20.2%) were women [Figure 3]. The proportion of female physicians will continue to approach that of males in the future, as over one third (36.4%) of the state's physicians under 35 years of age were women, as were 39% of the physicians younger than 30 years of age.

Nearly two thirds (64.7%) of North Carolina's physicians were between the ages of 35 and 54 in 1998. The percentage of physicians under 35 had declined to a 20-year low of 15.6%, after a peak of 24.2% in 1983. There were fewer older physicians in the state's work force as well, as fewer than one fifth (19.7%) of North Carolina's physicians were 55 years of age or older, the lowest percentage in the last 20 years.

scarcer in non-metropolitan areas of the state (see note), accounting for less than one twentieth (4.6%) of the total. By 1988, the percentage of physicians 55 years of age or older had

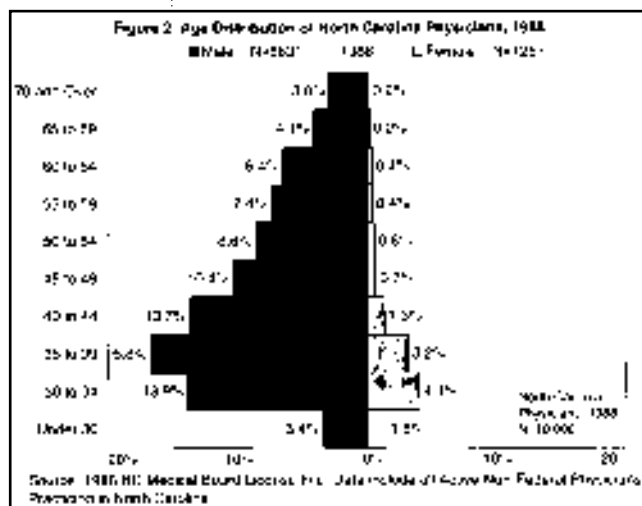


This report is another in a series of analyses made possible by 20 years of cooperation among the North Carolina Medical Board, the North Carolina Area Health Education Centers (AHEC) Program, and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. The North Carolina Medical Board has shared descriptive information contributed by licensed physicians as part of the annual registration process with the Sheps Center since 1976. The Center has published an annual report and has conducted numerous analyses for policy makers and professional associations using these data. The data used to produce this report are the property of the North Carolina Medical Board and are released only with permission of the Board or its executive director.

North Carolina Physicians' Age and Sex Distribution

In 1979, women made up 5.8% of North Carolina's active physician work force [Figure 1]. Over one quarter (27.4%) of the state's physicians were 55 years of age or older, and 16.2% were under 35 years old.

By 1988, the physician work force had become dramatically younger [Figure 2]. This was due to large increases in younger physicians rather than loss of older doctors, as the total number of physicians 55 or over had increased. The proportion of physicians in the 35 to 54 range had not changed much from 1979 (56.5% to 55.1%), but the percentage of



declined by 18% to 28.4%. A higher proportion of rural physicians was 55 or older than in urban areas of the state in 1998, with 22.3% of rural physicians being 55 or older. However, there were similar proportions of physicians between 35 and 54 (63.0% rural vs 65.2% urban) and physicians under 35 (14.7% rural vs 15.6% urban) compared to the rest of the state. The proportion of women physicians in rural North Carolina had increased sharply to 17.1%, with women accounting for 34.0% of rural physicians under 35 years of age. Although this is still a slightly lower proportion than for the state, it represents a greater proportional rate of increase in the period from 1988 to 1998 (67.1% to 61.7%).

Conclusions

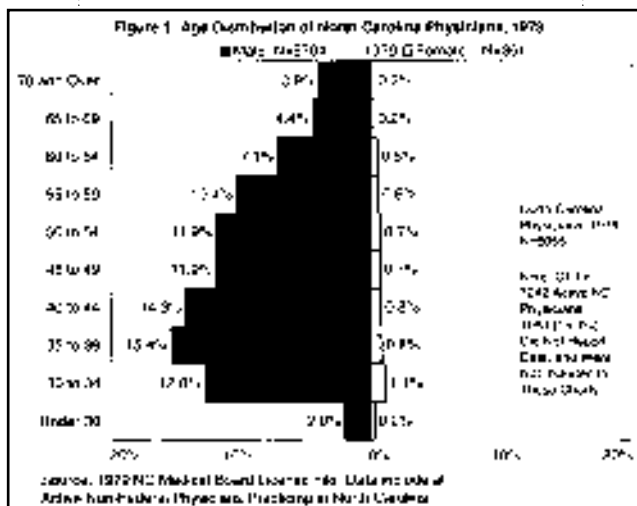
The supply of physicians in North Carolina is not subject to substantial changes due to retirement or death. In 1998, the proportion of the state's physician work force between the ages of 35 and 54 was the highest it had been in 20 years. This indicates that the supply will remain stable over the near term. The number of licensed, active physicians who are women has grown rapidly since 1978; however, it will take many years for the number of male and female physicians to near equality.

Note

To consistently compare the urban-rural distribution of physicians across 20 years, the 1993 OMB metropolitan definitions were used for all the years studied.

Sources

North Carolina Health Professions Data Book, Cecil G. Sheps Center for Health Services Research, 1979, 1988, 1998. ♦



Physician Demographics in Rural North Carolina

In 1979, rural North Carolina had a higher proportion of older physicians than the state, with over one third (33.4%) being 55 years of age or older. Women physicians were also

Recent Changes to PA and NP Prescribing Rules

R. David Henderson, JD
NCMB Legal Department

Effective May 1, 1999, the North Carolina Medical Board made several changes to the physician assistant (PA) and nurse practitioner (NP) rules. Our focus here will be on changes to the prescribing authority of PAs and NPs. Requirements retained from the old rules are restated; **changes are highlighted in bold type**. Rule references are to the new rules.

Physician Assistants

PA Rules (21 NC Administrative Code Chapter 32, Subchapter S)
Documentation Requirements:

- Every PA must maintain at all approved practice sites written prescribing instructions, signed by the PA and the supervising physician(s) ("SP"), which contain specific instructions from the SP to the PA regarding prescribing, ordering, and administering drugs and medical devices, and a policy for periodic review by the SP of the PA's prescribing, ordering, and administering drugs and medical devices. [PA Rule .0109(2)] **In addition, the new rules state the PA and SP must acknowledge that each is familiar with the laws and rules regarding prescribing and agree to comply with these laws and rules by incorporating them into the written prescribing instructions.** [PA Rule .0109(1)]
- Each prescription must be documented in the patient's record and include medication name and dosage, amount prescribed, directions for use, number of refills, signature of the PA, and cosignature by the SP within the time limits set forth in PA Rule .0110(c). [PA Rule .0109(6)]

Prescribing Controlled Substances:

- In order to prescribe controlled substances, both the PA and the SP must have a valid DEA registration. [PA Rule .0109(4)]
- In order to prescribe controlled substances, the old rule required the PA and SP to sign a statement that they had read and understood "the DEA MID-LEVEL PRACTITIONERS MANUAL and the information sheet provided by the Board." **The new rules do not mention this manual but, instead, state the PA and SP "shall prescribe in accordance with information provided by the Medical Board and the DEA."** [PA Rule .0109(4)]
- The old PA rule limited prescriptions for substances falling within the categories 2, 2N, 3, and 3N to a legitimate seven day supply. **The new PA rule states prescriptions for substances falling within these categories "shall not exceed a legitimate 30 day supply."** [PA Rule .0109(4)]

NOTE REGARDING PRESCRIBING OF SCHEDULES 2, 2N, 3, AND 3N CONTROLLED SUBSTANCES: The PA rules do not prohibit a PA from prescribing refills of category 2 and 2N substances but current DEA regulations do not permit this. A PA may write refills for 3 and 3N controlled substances but, as stated above, the total amount prescribed, including refills, may not exceed a legitimate 30 day supply.

Prescription Forms:

- Each prescription issued by a PA shall contain the PA's name, practice address, and telephone number; the PA's license number and, if controlled substances are prescribed, the PA's DEA registration number; and the SP's name and telephone number. [PA Rule .0109(5)]

Professional Medication Samples:

- PAs who request, receive, and dispense to patients professional medication samples must comply with all applicable state and

federal regulations. [PA Rule .0109(7)]

Compounding and Dispensing Drugs:

- In order to compound and dispense drugs, PAs must obtain approval from the North Carolina Board of Pharmacy and follow all Board of Pharmacy rules and federal guidelines. [PA Rule .0109(3)]

Procuring Drugs:

- **Language added at the beginning of PA Rule .0109 now permits PAs to procure and dispense drugs and medical devices. This is in addition to permission granted in the old rules to "prescribe, order, and administer."**

Nurse Practitioners

NP Rules (21 N.C. Administrative Code Chapter 32, Subchapter M)
Documentation Requirements:

- Every NP must maintain at all practice sites written protocols (formerly known as written standing protocols), signed by the NP and the SP, which specify, among other things, the drugs and devices that may be prescribed, ordered, and implemented by the NP. [NP Rules .0109(b)(3) and .0108(b)(1)]
- Each prescription shall be noted on the patient's chart and include medication and dosage, amount prescribed, directions for use, number of refills, and signature of the NP. [NP Rule .0108(b)(5)]

Controlled Substances:

- An NP may prescribe or order controlled substances so long as he/she has a valid DEA registration number which is entered on each prescription for controlled substances. [NP Rule .0108(b)(2)(A)] **The new rules also allow an NP to procure controlled substances so long as he/she has a valid DEA registration number.** [NP Rule .0108(b)(2)]
- With a few exceptions, the old NP rules limited prescriptions for substances falling within categories 2, 2N, 3, and 3N to a seven day supply. **The new NP rule states prescriptions for substances falling within these categories "are limited to a 30 day supply."** [NP Rule .0108(b)(2)(B)] Prescriptions for these schedules may not be refilled. [NP Rule .0108(b)(2)(C)] However, since current DEA regulations do not permit refills of category 2 and 2N substances, this restriction applies, in effect, only to category 3 and 3N substances.

Other Prescribing Requirements:

- NPs may prescribe a drug not listed in the written protocols only if (1) there is a specific written or verbal order from the SP before the prescription or order is issued by the NP, and (2) said written or verbal order is entered in the patient record with a notation that it is issued on the specific order of the SP and the notation is signed by the NP and SP. [NP Rule .0108(b)(3)] See also NP Rule .0101(11) ("... **Clinical practice issues that are not covered by the written protocols require nurse practitioner/physician consultation, and documentation related to the treatment plan.**")
- Refills may be issued for a period not to exceed one year; however, as noted above, schedules 2, 2N, 3, and 3N may not be refilled. [NP Rule .0108(b)(4)]

Prescription Forms:

- All prescriptions issued by an NP shall contain the SP's name, the name of the patient, and the NP's name, telephone number, and prescribing number assigned by the Medical Board. In addition,

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Recent Changes to PA/NP Prescribing Rules

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if a controlled substance is prescribed, the prescription shall contain the NP's DEA registration number. [NP Rules .0108(b)(6) and (7)]

Dispensing Drugs:

- An NP may obtain approval to dispense the drugs and devices specified in the written protocols from the North Carolina Board of Pharmacy and must dispense in accordance with all Board of Pharmacy rules. [NP Rule .0108(c)]

Summary

Most of the language from the old PA and NP prescribing rules remains in effect. However, the new PA rules require the PA and SP to acknowledge that each is familiar with the laws and rules regarding prescribing and agree to comply with these laws and rules by incorporating them into the written prescribing instructions. While PAs are no longer required to read the DEA Mid-Level Practitioners Manual, they are required to prescribe in accordance with information provided by the Medical Board and the DEA. PAs may now prescribe categories 2, 2N, 3, and 3N substances in an amount not to exceed a legitimate 30 day supply. Due to DEA regulations, prescriptions for categories 2 and 2N may not be refilled. Prescriptions for categories 3 and 3N may be refilled so long as the total amount prescribed does not exceed a legitimate 30 day supply. Finally, PAs may now procure and dispense drugs and medical devices.

The new NP rules also permit NPs to prescribe a 30 day supply of substances falling within categories 2, 2N, 3, and 3N; however, as before with the old rules, refills are expressly prohibited. Under the new rules, NPs are now permitted to procure controlled substances, in addition to prescribe and order, so long as the NP has a valid DEA registration and this is permitted by the written protocols. Finally, if an NP prescribes a drug not listed in the written protocols, the new rules require the SP to co-sign the NP's notation of this prescription in the patient record.

Copies of the PA and NP rules may be ordered by leaving a message at 1-800-253-9653, ext. 269 (NC & VA) or 1-919-326-1109, ext. 269. Also, these rules can be found on our Web site at www.docboard.org/nc. Click on Rules in the directory. The PA prescribing rules begin at page 53 and the NP prescribing rules begin at page 42. ♦

REVIEW

When Is It Futile?

Walter J. Pories, MD
Member, NCMB



Dr Pories

The challenge usually comes in two forms:

- "Doctor, please stop it. We all have to die. This is futile."
- "Care at the end of life is one of the biggest costs in medicine. You doctors will just have to learn to avoid that expense. It's futile."

Both statements are true. Neither is usually very useful. Who among us has not wrestled with these thoughts at the bedside of the elderly patient on dialysis? Who has not grappled with the decision to open the chest of a boy in cardiac arrest who is lifeless, shot 20 minutes earlier through the chest?

The decision when to stop treatment or progress from therapy to palliation remains one of medicine's great challenges, especially in this decade of increasing technology, measures that now enable life in situations previously regarded as hopeless. Accordingly, I was delighted to run across *When Doctors Say No: The Battleground of Medical Futility* by Susan B. Rubin, a "philosopher and bioethicist, a co-founder of The Ethics Practice, a California firm devoted to providing bioethics education, research, and clinical consultation." Ahh, here is an expert who may illuminate this dark tunnel of our practice.

What a disappointment. She not only fails to address the two real challenges noted in my first paragraph, she replaces these with a flimsy third thesis. She claims that physicians make decisions about medical futility on their own without consulting others. She rejects "the popular arguments supporting unilateral decision making by physicians and calls instead for a different kind of conversation about the central values at stake when doctors and patients so dramatically disagree."

Dr Rubin, you need to get out more. In my many years of practice in a variety of settings, ranging from trauma centers to small hospitals, as well as military hospitals during our wars, I rarely found a physician making a unilateral decision regarding the futility of treatment. In contrast, I encountered just the opposite. Physicians invariably seek help and advice from families, friends, colleagues, nurses, social workers, ministers, and ethicists before cessation of treatment. Further, "dramatic disagreements" between doctors and patients are also a rare occurrence. No, instead we often sit long hours with patients and their families, pondering the future and how to address it with kindness, control of pain, husbandry of resources, and affection. Even at the end of the drama of failed cardiac arrest, the senior physician will always ask, "I think it's time. Agree?" Deciding when someone is to die is too heavy a decision for us, as physicians, to make alone. In contrast to Dr Rubin's contention, we do not reject advice, we seek it.

When Doctors Say No: The Battleground of Medical Futility

Susan B. Rubin

(in the *Medical Ethics Series*, edited by Smith and Veatch)

Indiana University Press, Bloomington and Indianapolis, 1998

191 pages (notes, bibliography, index), \$24.95 cloth

(ISBN 0-253-33463-2)

Unfortunately, Dr Rubin concentrates on a non-issue and misses the big one: how do we know when our therapies will be futile? I have seen a young Air Force sergeant recover apparently full faculties after two years of coma. When I ran the Hospice in Cleveland, Ohio, we were sent a moribund woman with massive metastatic breast cancer, clearly ready to die, who, after we treated her with hydration, hormones, and chemotherapy, lived another five years, long enough to watch her children graduate from high school. On the other side of the coin, I have also despaired at the costs, both fiscal and emotional, incurred by the septic patient with necrotizing fasciitis who finally died after a number of operations and months in

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When is it Futile?

continued from page 15

the intensive care unit.

Dr Rubin's failure to focus may be due to her turgid writing: "My conceptual analysis of futility will treat each epistemological question separately." Or how about this sentence?

Though the leaky bucket metaphor and its underlying presumptions have been used, perhaps unwittingly, to support normative arguments in favor of physician authority to refuse unilaterally to provide treatment on the grounds of futility, neither the metaphor nor its underlying presumptions are problem free.

That's tough reading, and not worth the time. Too bad, too; the challenge of "futility" deserves far more emphasis. As a society, we need to address this issue. Do we follow the lead of our British colleagues who ration by resources, the Colorado Medicaid format that limits by a list of therapies, or do we continue to muddle on with continuing arguments about cost while ignoring compassion? Where are the data to help us make these decisions?

We are still waiting for the book that will help us with these decisions. So far, the Bible and the Koran still seem to be the best authorities. Let me recommend that you continue to read these two references until something better than Dr Rubin's book comes along. ♦

Informative Video Tapes

The Magic Kiss: Sexual Misconduct and Boundary Violations [114 minutes; 1997]

A seminar conducted at the offices of the NCMB by Barbara S. Schneidman, MD, MPH, then Associate Vice President of the American Board of Medical Specialties and now Director of the AMA Office of Medical Education Liaison and Outreach. This is the presentation Dr Schneidman has made before a number of state medical boards and other medical groups over the past several years. **Available from the NCMB's Public Affairs Office for \$10.00 (which includes mailing charge).** (Please inquire for costs if requesting shipping outside the U.S.)

Edmund D. Pellegrino: "Why Do We Speak of Responsibility?" [25 minutes; 1994]

Distinguished medical ethicist discusses the duties of medical board members, the ethics of medical practice, and the role of medical educators. Dr Pellegrino is Director of the Center for Clinical Bioethics at Georgetown University Medical Center. **Available from the NCMB's Public Affairs Office for \$12.95 (which includes mailing charge).** (Please inquire for costs if requesting shipping outside the U.S.) ♦



LETTER TO THE EDITOR



Two Questions: Romantic Relationships, Splitting Fees

To the Editor: Ever since I read a scenario in the *Forum*, I have wondered whether there was more to the story than was written because it raised questions about what I think may be a common circumstance, especially in smaller towns. The item appeared sometime in the past year or so. [*Forum* #4, 1997, page 24.]

As I recall, the case concerned a male MD in a multi-physician group who gave a physical to one of the female employees who did not work directly for or with him. Some time after this, they started dating and having a sexual relationship. The *Forum* indicated that the man's license was suspended, placed on probation, or canceled—I can't recall which, but any of the three sounded awfully severe. (And who filed the complaint that brought it to the Board's attention anyway? The employee? Another, perhaps jealous, employee or patient? Or some anonymous observer? Does that make a difference? Who or what determines "no harm, no foul"?) Would it have made a difference if the employee worked directly for or with the doctor, was paid by him?

I understand that "consensual," in some instances (eg, professor and student, CEO and middle manager), may raise questions, per se, of propriety/ethics, but where is the line drawn? A patient who happens to be the mayor is inherently in a position that may make the doctor actually the one who could be "beholden." (An "inherently unequal" relationship actually is the norm for almost any relationship, if you choose to see it that way.) "The very appearance of impropriety is enough to assume impropriety"? If so, "impropriety" in whose eyes? Also, eg, how many wives work in their husbands' offices, whether in a clinical or a non-clinical capacity? (And does the latter distinction make any difference?) If that is all right, what if they were just engaged or just dating? At what point is it questioned by the Board?

Does someone have to file a complaint? And does that someone have to be verified as not having his or her own ax to grind in the situation?

So, my question concerns to what length the North Carolina Medical Board takes this. For example, if I, as a specialist, am asked to see a patient in consultation for a brief peri-

od of time, does that mean that if I am asked out to dinner by that (former) patient five years later I am unethical if I accept and could have my license yanked and black marks on my record forever? Or, if I am already friends with that person from church or school or if I am already dating that person, if they come to me because they already know me, and we continue or start to date, is that relationship with the patient unethical in the Board's eyes? And what does the parameter of during or after—and how long after—the limited doctor-patient interaction matter? What if it is an ongoing but intermittent relationship, such as sewing a laceration or freezing a wart? If there is any middle ground, does it revolve around whether or not there is a sexual component? If so, how sexual? What makes a difference to the Board: a good-night kiss, a thank-you hug, an arm around the shoulder, holding hands, or a Clintonesque contact?

It seems there's an awfully slippery slope here. Especially in a small town there may be "slim pickins" for a single doctor who is still interested in having relationships, and the odds are high that some of the scenarios I've suggested could obtain.

Perhaps I misread the original article, but I believe you can tell where I would like some clarification.

Also, in that same issue [#4, 1997, page 13], there was a reference to not being allowed to split profits with other health care workers, except as allowed under a specific statute, which was not explained. Could you explain that statute? And does this mean that if a more experienced associate (but not legal partner) of mine or even someone in another practice helps me on a complicated procedure that I am not allowed to say thank you in a monetary way? (Say a procedure not allowed to be coded for an assistant's fee.)

Thanks in advance for responding to my concerns.

A North Carolina Physician

Response

Volumes have been written on your first question and I'll not try to reproduce them here. Your description might apply to several recent cases, so I'll also not try to elaborate on any particular case. There would be further public record beyond what was in the Forum, but the Forum is usually a close paraphrase of the legal documents in the public record.

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Letter to the Editor

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Each case is decided on its own facts. Generally, in "boundary violation" cases, as we generically refer to them, we are looking for an abuse of the power differential inherent in the physician/patient relationship, just as you suggest. Abuses of the power differential in the employment relationship, coupled with dissolved or dissolving boundaries in the physician/patient relationship, might be worrisome in themselves or suggestive of worse things to come. Treating anyone with whom the physician has a personal or other relationship (beyond the physician/patient relationship) could also be considered a boundary violation, though perhaps a less severe one. It also frequently leads to care provided to a lower standard than that provided those who are simply patients.

The Board gets its information from a variety of sources. For the Board to have acted, either the physician must have admitted the conduct in the accusation or the Board must have proven it. An unverified complaint from someone with an ax to grind might get an investigation started, but it usually won't win at trial.

Exploitation of the power differential being the issue, the more recent and extensive the con-

tact between patient and physician, the more likely the Board is to see a problem. Standards certainly were different in the past when many communities had only one physician and when physicians generally did not go outside their communities for dates or anything else. In 1999 North Carolina, the Board might doubt your "small town defense."

Your reference to the statutory "exception" to the prohibition against fee splitting is probably NC Gen Stat 55B-14(c), the one allowing physicians and certain others to own shares together in a single professional corporation (eg, psychiatrists and psychologists; ophthalmologists and optometrists).

Thanks for reading the Forum.

James A. Wilson

Director

NCMB Legal Department ♦

Audio Tape: "End-of-Life Decisions Forum"

End-of-Life Decisions Forum [4 hours; 1998]

Transcription of a conference developed and presented by the staffs of the North Carolina Medical Board, the North Carolina Board of Nursing, and

the North Carolina Board of Pharmacy. Held in Raleigh, North Carolina, on October 23, 1998, the conference was designed to provide a forum for health care regulators, professionals, and policy makers to explore the ethical, legal, and other issues surrounding end-of-life decisions and to initiate a continuing process for addressing such issues. Speakers included Lawrence O. Gostin, JD, LLD (Hon), Co-Director of the Johns Hopkins University and Georgetown University Program on Law and Public Health; George C. Barrett, MD, Vice President of the Federation of State Medical Boards and past president of the North Carolina Medical Board; Anne Dellinger, JD, Professor of Public Law and Government at the University of North Carolina; Bill Campbell, PhD, Dean of the University of North Carolina School of Pharmacy; David A. Swankin, JD, President of the Citizen Advocacy Center; Nancy M.P. King, JD, Associate Professor of Social Medicine at the University of North Carolina; Sharon Dixon, RN, MPH, Senior Vice President of Clinical Services at the Hospice of Charlotte; Joseph A. Buckwalter, MD, President of the North Carolina Hemlock Society; Cathy Clabby, MA, Medical Reporter for the Raleigh News and Observer; and the executive directors of the three host boards. On two 120 - minute audio cassettes. Available from the NCMB's Public Affairs Office for \$10.00 (which includes mailing charge). (Please inquire for costs if requesting shipping outside the U.S.) ♦

North Carolina Medical Board Meeting Calendar, Application Deadlines, Examinations November 1999 -- September 2000

Board Meetings are open to the public, though some portions are closed under state law.

North Carolina Medical Board

November Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

November 17-20, 1999

October 4, 1999
October 6, 1999
November 2, 1999

North Carolina Medical Board

January Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

January 19-22, 2000

December 6, 1999
November 24, 1999
January 4, 2000

North Carolina Medical Board

March Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

March 15-18, 2000

January 31, 2000
January 28, 2000
February 29, 2000

North Carolina Medical Board

May Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

May 24-27, 2000

April 10, 2000
March 24, 2000
May 9, 2000

North Carolina Medical Board

July Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

July 19-22, 2000

June 5, 2000
July 5, 2000
July 3, 2000

North Carolina Medical Board

September Meeting Deadlines:

Nurse Practitioner Approval Applications
Physician Assistant Applications
Physician Licensure Applications

September 20-23, 2000

August 7, 2000
September 5, 2000
September 5, 2000

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

The May 1999 administration of the USMLE Step 3 was the last pencil and paper administration. Computer-based testing for Step 3 is expected to be available on a daily basis in November 1999. Applications may be obtained from the office of the North Carolina Medical Board by telephoning (919) 326-1100. Details on administration of the examination will be included in the application packet.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at 400 Fuller Wiser Road, Suite 300, Euless, TX 76039 or telephone (817) 868-4000.

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

May, June, July 1999

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

A term used for this report to indicate restrictions or requirements placed on the licensee/licensee.

Consent Order:

An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

Denial:

Final decision denying an application for practice

authorization or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

License to practice medicine for a specific period of time. Often accompanied by conditions contained in a Consent Order. May be issued as an element of a Board or Consent Order or subsequent to the expiration of a previously issued temporary license.

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending an investigation or in lieu of disciplinary action.

ANNULMENTS

NONE

REVOCATIONS

NONE

SUSPENSIONS**TRITES, Paul Nathan, MD**

Location: Richfield, MN

DOB: 8/13/1953

License #: 0000-27326

Specialty: OPH/IM (as reported by physician)

Medical Ed: University of Minnesota (1980)

Cause: A hearing before the Board on 5/20/1999 on charges dated 10/06/1998. Dr Trites was disciplined by the Minnesota Board of Medical Practice on or about 1/10/1998 for failure to record adequate information in the medical records of three patients, failure to promptly provide medical records to two patients, and failure to cooperate with the Minnesota Board's investigation of his practice. In testimony before the North Carolina Medical Board, he continued to blame former staff members and attorneys for the problems cited. He presented a copy of an Order of Unconditional License dated 3/13/1999 in which the Minnesota Board conferred on him an unconditional license to practice; however, he did not prove to the North Carolina Board that he has corrected the underlying problems that led to the discipline imposed by Minnesota.

Action: 6/10/1999. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Trites' North Carolina medical license is suspended indefinitely.

See Consent Orders:

CLARK, Richard Stroebe, MD

NOONAN, Kevin Bernard, MD

WESSEL, Richard Fredrick, Jr, MD

SUMMARY SUSPENSIONS**DIAMOND, Patrick Francis, MD**

Location: Evergreen, NC (Columbus Co)

DOB: 5/15/1946

License #: 0098-00042

Specialty: FP (as reported by physician)

Medical Ed: Universidad Autonoma de Tamaulipas, Mexico (1987)

Cause: Upon information that Dr Diamond may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality.

Action: 6/28/1999. Order of Summary Suspension of License issued, effective 7/01/1999. [Notice of Charges issued 6/28/1999.]

CONSENT ORDERS**AQUILINA, Joseph Nicholas, MD**

Location: Saginaw, MI

DOB: 3/07/1935

License #: 0000-38581

Specialty: U (as reported by physician)

Medical Ed: University of Munich, West Germany (1962)

Cause: Dr Aquilina admits and the Board finds that by an order of 11/17/1998, the Wyoming Board of Medicine restricted Dr Aquilina's license based on false answers submitted by him on his license renewal applications in 1997 and 1998.

Action: 5/26/1999. Consent Order executed: Dr Aquilina shall not practice medicine in North Carolina unless and until the following requirements are met and the Board issues an order permitting such practice: should he desire to practice in North Carolina, he shall first notify the Board and he shall then be interviewed to determine if he can practice safely and skillfully and if he possesses the character and integrity expected of North Carolina physicians; must comply with other conditions.

BORISON, Richard Lewis, MD

Location: Augusta, GA

DOB: 3/04/1950

License #: 0096-00068

Specialty: P/PYG (as reported by physician)

Medical Ed: University of Illinois (1977)

Cause: Dr Borison has been disciplined by the Georgia medical board and surrendered his Georgia license in October 1998; he executed a plea agreement, which was accepted by the Superior Court of Richmond County, Georgia, in October 1998 in which he admitted he was guilty of one RICO count, 18 counts of Theft by Taking, 10 counts of Theft of Services, and 7 counts of False Statements and Representations.

Action: 7/24/1999. Consent Order executed: Dr Borison surrenders his North Carolina license immediately.

BOSHOLM, Carol Christine, MD

Location: Hendersonville, NC (Henderson Co)

DOB: 10/10/1953

License #: 0096-00151

Specialty: IM (as reported by physician)

Medical Ed: University of Medicine and Dentistry of New Jersey (1989)

Cause: On information that Dr Bosholm has been disciplined by the New York State Board for Professional Medical Conduct. The Board finds and she admits that by an Order dated 12/05/1997 New York placed her license on probation for five years based on false answers submitted by her on her New York license application.

Action: 6/25/1999. Consent Order executed: the Board reprimands Dr Bosholm.

BROOKS, Michael Lee, MD

Location: Pembroke, NC (Robeson Co)
 DOB: 11/24/1950
 License #: 0000-28845
 Specialty: IM/EM (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1979)
 Cause: From March to May 1998, DAC Health, Inc, acting through Dr Brooks and various PAs in its employ, rendered medical care to patients in Raeford, NC, although, under the "corporate practice doctrine," a business corporation generally may not practice medicine. Thus, it engaged in the unauthorized practice of medicine. Dr Brooks assisted in this unauthorized practice, permitting DAC Health to bill patients and third-party payors and to collect payments for all medical services rendered by him; from these fees, DAC Health paid Dr Brooks salary and kept the remainder to pay expenses and as profit; by splitting fees with DAC Health, Dr Brooks engaged in unprofessional conduct. On March 9, 1998, Robert M. Chavis, PA, began practicing at DAC Health under Dr Brooks supervision even though the Board did not approve Mr Chavis' notification of intent to practice until March 19; Dr Brooks should have verified Mr Chavis' status and should not have supervised a PA who was not approved; in doing this, Dr Brooks assisted in the unauthorized practice of medicine. While employed by DAC Health, Dr Brooks dispensed prescription drugs for a fee to his patients even though he was not registered with the Pharmacy Board, thus violating a law involving the practice of medicine. Dr Brooks failed to countersign 7 charts of patients seen by Mr Chavis within the time required by rule; he did countersign charts for 2 patients seen at DAC Health before he came to there and with whose care he had nothing to do. He states he was unaware his working at DAC Health was improper and that he quit working for DAC Health when he became aware of certain problems. He has been cooperative and has acknowledged his wrongdoing.

Action: 7/22/1999. Consent Order executed: Dr Brooks is reprimanded.

CHEN, Jackson Wushoung, MD

Location: Oak Brook, IL
 DOB: 11/13/1941
 License #: 0000-18357
 Specialty: PD/FP (as reported by physician)
 Medical Ed: National Taiwan University, ROC (1966)
 Cause: Dr Chen executed a Consent Order with the Illinois Department of Professional Regulation on 4/2/1998 under which he was reprimanded and his license subjected to various probationary terms. [A copy of the Illinois Consent Order is attached to this Consent Order and says, among other things, that information had come to the attention of the Department that he provided medical services to an entity which was precluded from engaging in treatment of patients pursuant to Illinois law and that he allegedly failed to follow proper protocols with regard to hospital admission of patients, procedures relating to dispensing of controlled substances and communication with other physicians involved in patient care. Dr Chen denied the allegations but accepted the terms and conditions of the Consent Order. Among other things, his license was placed on probation for one year and he was fined \$10,000.00; his Illinois controlled substance license was suspended for a period of 90 days.]

Action: 7/8/1999. Consent Order executed: The Board reprimands Dr Chen; he shall comply in all respects with the Illinois Consent Order; each calendar year, beginning with 1999, Dr Chen shall obtain and document to the Board 50 hours of practice-relevant Category I CME; must comply with other terms and conditions.

CLARK, Richard Stroebe, MD

Location: Memphis, TN
 DOB: 10/27/1938
 License #: 0000-32670
 Specialty: GS/NTR (as reported by physician)
 Medical Ed: University of Southern California, Los Angeles (1959)
 Cause: Dr Clark admits and the Board finds that he was disciplined by the Arkansas State Medical Board on 7/18/1998 for pre-signing blank prescriptions in violation of state and federal laws and that his Arkansas license was suspended from 6/04/98 to 9/01/1998.

Action: 5/19/1999. Consent Order executed: Dr Clark's North Carolina medical license is suspended retroactively from 6/04/1998 to 9/01/1998; to the extent he has not already done so, he shall comply with the terms of the Order entered by the Arkansas Board on 7/18/1998 and as that Order may be amended; in 1999, he shall obtain 50 hours of practice-relevant Category I CME, at least 25 hours of which must be in a public forum; must comply with other conditions.

CROLAND, David Alan, DO

Location: Little River, SC
 DOB: 11/27/1962
 License #: 0097-01729
 Specialty: FP (as reported by physician)
 Medical Ed: Southeastern College of Osteopathic Medicine (1989)
 Cause: To amend an existing Consent Order. Dr Croland entered a Consent Order with the South Carolina board in which he admitted, among other things, that he furnished fraudulent information in orders and documents purporting to be prescriptions, which were issued outside the reasonable bounds of a practitioner-patient relationship and for other than legitimate medical purposes, that he furnished fraudulent documents to obtain and supply his office with fentanyl and other controlled substances for administration to himself, and that he furnished false and fraudulent material information to his medical records that indicated he administered fentanyl and other controlled substances to patients when he had in fact used them himself; he later applied for a license in North Carolina and was issued a license pursuant to a Consent Order on 12/08/1997. He has asked that his Consent Order be amended so he can prescribe Schedule IIN controlled substances. It appears his recovery is going well and he has complied with the terms of his Consent Order.

Action: 5/11/1999. Consent Order executed: Dr Croland is issued a license to practice medicine; he shall maintain and abide by a contract with NCPHP; unless lawfully prescribed for him by someone else, he shall not consume alcohol, controlled substances, or any other abusable substance; at the Board's request, he shall supply bodily fluids or tissue for screening to determine if he has consumed alcohol, controlled substances, or any other abusable substance; he shall not use, dispense, administer, prescribe, or possess, in any manner, Schedule II controlled substances, Stadol, and Nubain, nor permit these drugs to be in his office for any purpose; he shall obtain drug and alcohol counseling from a therapist approved in writing by the president of the Board; he shall direct his therapist to send quarterly reports to the Board; he shall attend NA meetings as directed by his therapist and the NCPHP; must comply with other conditions; the numbered sections of this Consent Order supersede those imposing any continuing obligation in any prior consent order except those regarding the public nature of such consent orders.

DUNN, Clarence Alvin, Jr, MD

Location: New York, NY
 DOB: 12/05/1930
 License #: 0000-13790
 Specialty: ORS/OTR (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1963)
 Cause: On or about 2/09/1998, the New York Board issued a Determination and Order by which Dr Dunn's New York medical license was revoked for misconduct related to practicing medicine after he was aware his registration had lapsed, allowing a certification that had been altered to accompany his application for privileges on two occasions, and for willful failure to register.

Action: 6/29/1999. Consent Order executed: Dr Dunn surrenders his North Carolina license and the Board accepts that surrender.

ENGLEMAN, James Donald, Jr, MD

Location: Vanceboro, NC (Craven Co)
 Greenville, NC (Pitt Co)
 DOB: 4/05/1960
 License #: 0000-32696
 Specialty: FP (as reported by physician)
 Medical Ed: University of Louisville (1985)
 Cause: To amend an existing Consent Order. Dr Engleman surrendered his license in June 1995 after relapsing in his use of opiates; on October 12, 1998, he was issued a temporary license pursuant to a Consent Order of October 8, 1998; his current Consent Order says he may not work more than 30 hours a week and Dr Engleman has asked that limit be removed; the Board has agreed to his request.

Action: 5/07/1999. Consent Order executed: Dr Engleman is issued a license to expire on the date shown on the license; he shall practice only in a setting first approved by the Board's president; he shall arrange and pay for a physician monitor who shall be approved by the Board's president; the monitor shall regularly review Dr Engleman's practice and report to the Board quarterly; unless lawfully prescribed for him by someone else, Dr Engleman shall refrain from use of all mind and mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board in writing within 2 weeks of any

such use, identifying the prescriber and the pharmacy filling the prescription; at the request of the Board, he shall supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by a contract with NCPHP; he shall attend AA, NA, and/or Caduceus meetings as recommended by NCPHP; he shall maintain a monthly log of all controlled substances he prescribes, orders, or administers and deliver a copy of that log to the Board each month; he shall continue psychotherapy with his current therapist or such other person as may be approved by the Board's president; he shall direct his therapist to provide quarterly reports of his progress to the Board; he shall obtain 50 hours of Category I CME each year; must comply with other conditions.

FIUTOWSKI, Zdzislaw, MD

Location: Hamtramck, MI
 DOB: 12/19/1926
 License #: 0000-23925
 Specialty: GP (as reported by physician)
 Medical Ed: Medical Academy of Cracow, Poland (1954)
 Cause: In February 1997, the disciplinary committee of the Michigan Board filed an administrative complaint against Dr Fiutowski [which complaint stated his treatment of certain patients for helicobacter pylori infection was not appropriate and was contrary to acceptable medical standards]; in a Consent Order entered by the Michigan Board in March 1998, Dr Fiutowski admitted allegations contained in the administrative complaint, was reprimanded, and required to obtain 50 hours of Category I CME, including 10 hours of hospital grand rounds by March 1999.
 Action: 5/5/1999. Consent Order executed: Dr Fiutowski is reprimanded; he shall comply with the Consent Order he entered into with the Michigan Board; he shall submit to the Board evidence of the successful completion of the CME imposed by the Michigan Consent Order; must comply with other conditions.

GRAY, William Gilman, MD

Location: Roanoke, VA
 DOB: 9/08/1941
 License #: 0000-16585
 Specialty: CHP/P (as reported by physician)
 Medical Ed: Medical College of Virginia (1966)
 Cause: Regarding Summary Suspension and Notice of Charges and Allegations dated 3/21/1992 against Dr Gray. Dr Gray admits and the Board finds the Virginia Board of Medicine summarily suspended his license on 3/06/1992; the Virginia Board revoked Dr Gray's license by an Order of 11/10/1993 (a copy of which indicates that board found he failed, in some instances, to maintain adequate records with regard to treatment and prescription regimes for individuals under his care, he provided non-medical support to certain patients as a quid pro quo for sexual favors, and he exploited the physician/patient relationship by engaging in sexual activities with certain patients). Dr Gray intends never to practice in North Carolina.
 Action: 5/17/1999. Consent Order executed: Dr Gray surrenders his North Carolina Medical license and the Board accepts that surrender; this Consent Order shall remain in effect until specifically ordered otherwise by the Board.

McCREEDY, Phillip Allen, MD

Location: Golden, CO
 DOB: 4/09/1936
 License #: 0000-39852
 Specialty: OBG (as reported by physician)
 Medical Ed: University of Colorado (1962)
 Cause: Dr McCreedy has been disciplined by the Wisconsin and Wyoming medical boards. The Board finds and Dr McCreedy admits that by a Final Decision and Order of the Wisconsin board, dated May 21, 1998, that board accepted the surrender of Dr McCreedy's license based on allegations of various boundary violations; by a Consent Decree approved by the Wyoming board in November 1998, Dr McCreedy relinquished his Wyoming license based on false answers he submitted on his 1994 license application, his 1995 licensing interview, and his 1998 application for license renewal.
 Action: 5/07/1999. Consent Order executed: Dr McCreedy surrenders his license to practice in North Carolina.

MINDER, Joseph Kamel, MD

Location: Matthews, NC (Mecklenburg Co)
 DOB: 3/23/1952
 License #: 0000-39307
 Specialty: U/OS (as reported by physician)
 Medical Ed: American University of Beirut (1978)

Cause: In consideration of a motion to dismiss the Notice of Charges and Allegations dated 9/18/1998. Dr Minder maintains he has always tried and intended to preserve his patients' dignity and modesty; he acknowledges his manner of interacting with the two patients noted in the Notice of Charges and Allegations may have made them uncomfortable. He has undergone training to sensitize him to the concerns, anxieties, and fears of patients.
 Action: 6/25/1999. Consent Order executed: the Board dismisses the Notice of Charges and Allegations dated 9/18/1998 against Dr Minder.

NOONAN, Kevin Bernard, MD

Location: Newport Beach, CA
 DOB: 2/17/1951
 License #: 0094-00115
 Specialty: EM/GP (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1977)
 Cause: Regarding the Notice of Charges and Allegations against Dr Noonan dated 6/15/1998. Dr Noonan admits and the Board finds that during the times relevant herein, Dr Noonan practiced medicine at Pinnacle Health Care, Inc, in Havelock, NC; Pinnacle is a business corporation organized under the laws of Virginia and authorized to do business in North Carolina; from June 1995 through January 1998, Pinnacle, through Dr Noonan and various physician assistants employed by Pinnacle and supervised by Dr Noonan, rendered medical care to patients in the Havelock area and thus engaged in the unauthorized practice of medicine; under the "corporate practice doctrine," a business corporation generally may not practice medicine; by assisting in the unauthorized practice of medicine, Dr Noonan engaged in unprofessional conduct; he also permitted Pinnacle to bill patients and third party payors for services he rendered; from the fees collected by Pinnacle for his services, Dr Noonan was paid a salary, Pinnacle keeping the rest; by splitting with Pinnacle the fees he generated from practicing medicine, Dr Noonan engaged in unprofessional conduct; at time during 1997, three physician assistants under Dr Noonan's supervision practiced at Pinnacle before obtaining approval of notification of intent to practice and, in one case, before being licensed; by assisting the unauthorized practice of medicine by those three PAs, Dr Noonan engaged in unprofessional conduct; in September 1996, Dr Noonan began dispensing prescription drugs to patients for a fee even though he had not registered with the Pharmacy Board as required by law; though advised two times by a Board investigator of the need to register with the Pharmacy Board before dispensing prescription drugs, Dr Noonan continued to dispense without registering; by dispensing prescription drugs without a permit, Dr Noonan violated a law involving the practice of medicine.
 Action: 5/20/1999. Consent Order executed: Dr Noonan's North Carolina medical license is suspended for 30 days.

SCONTASAS, George John, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 12/17/1948
 License #: 0000-32852
 Specialty: ADD/N (as reported by physician)
 Medical Ed: University of Virginia (1977)
 Cause: To modify Dr Scontasas' Consent Order of 6/08/1998, which reissued his license on conditions related to his recovery from substance abuse. Recovery appears to be going well and the Board has determined to allow Dr Scontasas to apply for controlled substance registration with the DEA and, if granted, to prescribe, order, administer, dispense, or otherwise deal with controlled substances as defined by federal law.
 Action: 6/03/1999. Consent Order executed: Dr Scontasas is issued a license to expire on the date shown on the license; unless lawfully prescribed for him by someone else, Dr Scontasas shall refrain from use of all mind and mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board in writing within 2 weeks of any such use, identifying the prescriber and the pharmacy filling the prescription; at the request of the Board, he shall supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by a contract with NCPHP; he shall obtain and document to the Board 50 hours of Category I CME relevant to his practice each year; must comply with other conditions. The terms in the numbered paragraphs of this Consent Order supersede those imposing any continuing obligation in any prior Consent Order regarding Dr Scontasas, except those concerning the public nature of those orders.

SHIVE, Robert MacGregor, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 11/02/1933

License #: 0000-13226

Specialty: P (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1961)

Cause: To amend the Consent Order of 6/18/1997 pursuant to which the Board issued Dr Shive a series of temporary licenses on conditions related to his conduct with female patients. His practice is apparently going well and he hopes to see patients again and supervise other counselors. The Board has no objection to that under certain conditions and will permit him to prescribe, order, administer, or dispense drugs in his treatment of such patients.

Action: 5/19/1999. Consent Order executed: Dr Shive is issued a license to expire on the date shown on the license; he shall not meet with, interview, examine, treat, or otherwise interact with a female patient unless a chaperon is physically present in the room during the entire encounter; beginning in 1999, he shall obtain and document to the Board 50 hours of practice-relevant Category I CME each year; must comply with other conditions. The terms of this Consent Order supersede those in any prior Consent Order between the Board and Dr Shive, except those regarding the public nature of those orders and those imposing any reprimand. This Consent Order does not change any aspect of Dr Shive's license status during any prior period.

SOROHAN, Jonathan Griffin, MD

Location: Conyers, GA

DOB: 9/09/1964

License #: 0096-01732

Specialty: AN (as reported by physician)

Medical Ed: Medical College of Georgia (1992)

Cause: Regarding the Notice of Charges against Dr Sorohan dated 4/16/1997; Dr Sorohan admits and the Board finds that he has had a problem with substance abuse, specifically fentanyl that he obtained from supplies at his residency training program at Duke University Medical Center; the Board summarily suspended his license effective 4/23/1997. Dr Sorohan has told the Board he wishes to enter substance abuse treatment.

Action: 5/20/1999. Consent Order executed: Dr Sorohan surrenders his North Carolina medical license, which he shall deliver to the Board within 10 days; the Board dismisses without prejudice the Notice of Charges of 4/16/1997.

THOMPSON, Robert Bruce, MD

Location: Charlotte, NC (Mecklenburg Co)

DOB: 2/29/1956

License #: 0000-40006

Specialty: N/EM (as reported by physician)

Medical Ed: University of Miami (1987)

Cause: On the application of Dr Thompson for reissuance of his license. He was suspended in July 1995 for failure to register and was reinstated in December 1996 pursuant to a Consent Order related to his recovery from substance abuse and his mental health; he relapsed in his recovery from substance abuse by drinking alcohol in June 1998; following treatment, he was issued a temporary license under a Consent Order of 9/18/1998; he was unable to attend an interview with the Board in November 1998 and his license was allowed to expire. He continues in long-term treatment for substance abuse and remains under the care of his psychiatrist.

Action: 7/07/1999. Consent Order executed: Dr Thompson is issued a license to practice medicine expiring on the date shown on the license (July 31, 1999); he shall practice only in a structured setting after that setting has been approved by the president of the Board in writing; he shall maintain and abide by a contract with NCPHP; unless lawfully prescribed by someone else, he shall refrain from the use of all mind or mood altering substances and all controlled substances and from alcohol; he shall notify the Board in writing within two weeks of his use of such medication or alcohol and note the prescriber and the pharmacy filling the prescription; he shall supply bodily fluids or tissues as requested by the Board for drug and alcohol screening; he shall continue to see his psychiatrist once each month and his psychologist twice each month and shall cause each to submit reports of his progress to the Board every three months; he shall obtain 50 hours of CME relevant to his practice each year, at least 30 of which shall be in Category I; must comply with other conditions.

WESSEL, Richard Fredrick, Jr, MD

Location: Elizabeth City, NC (Pasquotank Co)

DOB: 1/24/1959

License #: 0096-00772

Specialty: C/IM (as reported by physician)

Medical Ed: Eastern Virginia Medical School (1990)

Cause: Regarding reissuance of Dr Wessel's medical license. Dr Wessel admits and the Board finds that while on call one evening, he consumed wine and later, when paged, went to the hospital and installed a temporary pacemaker in a patient; when paged later that evening regarding a second patient, he was ordered to submit a sample of his blood to determine his blood alcohol level; instead of submitting a sample of his own blood, he went to the room of one of his patients, drew blood from that patient's IV line without any medical purpose, and submitted that blood sample as his own; when this was discovered, the hospital suspended his privileges and reported to the Board; at the Board's request, he surrendered his license on 5/07/1999. The Board met with Dr Wessel on 5/21/1999; he was cooperative and acknowledged the wrongful nature of his conduct, exhibiting genuine remorse. He has undergone substantial assessment and it appears he does not have an alcohol or other chemical dependency.

Action: 6/14/1999. Consent Order executed: Dr Wessel's license is reissued effective 5/07/1999; his license is suspended for the period from 5/07/1999 through 7/06/1999; unless lawfully prescribed for him by someone else, Dr Wessel shall refrain from use of all mind and mood altering substances and all controlled substances and from the use of alcohol; he shall notify the Board in writing within 2 weeks of any such use, identifying the prescriber and the pharmacy filling the prescription; at the request of the Board, he shall supply bodily fluids or tissue for screening to determine if he has consumed any of these substances; he shall maintain and abide by a contract with NCPHP; he shall obtain and document to the Board at least 30 hours of Category I CME relevant to his practice each year; must comply with other conditions.

WILLIAMS, David Randall, MD

Location: Columbus, NC (Polk Co)

Hendersonville, NC (Henderson Co)

DOB: 1/10/1950

License #: 0000-31218

Specialty: U (as reported by physician)

Medical Ed: University of South Alabama (1982)

Cause: The Board finds and Dr Williams admits that he engaged in a sexual relationship with a person who was also his patient from February 1993 through October 1993 and that he repeatedly made inappropriate and obscene comments and gestures about or to patients and staff from 1987 through 1998.

Action: 5/04/1999. Consent Order executed: Dr Williams surrenders his license to practice effective midnight May 21, 1999; he shall wind down his practice in an orderly fashion, assist his patients in ensuring continuity of care, and preserve patient records and access thereto; he shall return his license and registration certificates to the Board.

MISCELLANEOUS BOARD ORDERS

NONE

DENIALS OF LICENSE/APPROVAL**NORRIS, Dolly Frances, MD**

Location: Winterville, NC (Pitt Co)

DOB: 10/03/1966

License #: 0096-01782

Specialty: GP (as reported by physician)

Medical Ed: Uniformed Services University of the Health Sciences (1992)

Cause: The Board annulled Dr Norris' license by an order of 7/27/1998. It then denied her application for a license dated on or about 10/06/1998. On 1/19/1999, Dr Norris requested a hearing on this decision. The hearing was held on 3/18/1999. The Board found that, for her first application, Dr Norris had prepared and forged signatures on letters of recommendation purportedly from the director and a faculty member of the Wichita Falls Family Practice Residency Program. She also gave a false answer on her first application for a license and in her interview with members of the Board in November 1996. Additionally, her application for a license in Utah was denied in December 1996, that denial being reaffirmed in January 1997. At the hearing on 3/18/1999, she presented no evidence of any reformation of her character, showed no remorse or repentance, and blamed others for her own conduct. She is not of good moral character.

Action: 7/6/1999. Findings of Fact, Conclusions of Law, and Order issued: Dr Norris' application for a license is denied.

DENIALS OF RECONSIDERATION/MODIFICATION
NONE

SURRENDERS

MIJANOVICH, James Robert, MD

Location: Columbus, NC (Polk Co)
DOB: 2/23/1952
License #: 0000-34405
Specialty: PTH/GP (as reported by physician)
Medical Ed: Loyola University Stritch School of Medicine (1980)
Action: 6/16/1999. Voluntary surrender of medical license.

PERKERSON, Ralph Benton, Jr, MD

Location: Jacksonville, FL
DOB: 9/18/1948
License #: 0000-18285
Specialty: DR/NM (as reported by physician)
Medical Ed: Medical College of Georgia (1971)
Action: 7/12/1999. Voluntary surrender of medical license.

WESSEL, Richard Fredrick, Jr, MD

Location: Elizabeth City, NC (Pasquotank Co)
DOB: 1/24/1959
License #: 0096-00772
Specialty: C/IM (as reported by physician)
Medical Ed: Eastern Virginia Medical School (1990)
Action: 5/07/1999. Voluntary surrender of medical license.

See Consent Orders:

BORISON, Richard Lewis, MD
DUNN, Clarence Alvin, Jr, MD
GRAY, William Gilman, MD
McCREEDY, Phillip Allen, MD
SOROHAN, Jonathan Griffin, MD
WILLIAMS, David Randall, MD

CONSENT ORDERS LIFTED

BLAKE, Daniel Jackson, MD

Location: Black Mountain, NC (Buncombe Co)
DOB: 4/12/48
License #: 0000-23830
Specialty: P/ADD (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Action: 6/10/1999. Order issued lifting Consent Order of 5/23/1996.

BRANCH, Robert Donald, Physician Assistant

Location: Kinston, NC (Lenoir Co)
DOB: 7/07/1958
License #: 1-02026
PA Education: University of Texas (1995)
Action: 6/10/1999. Order issued lifting Consent Order of 8/11/1998.

HUNSAKER, Robert Huson, MD

Location: Key Biscayne, FL
DOB: 2/04/1956
License #: 0000-28050
Specialty: PS/GS (as reported by physician)
Medical Ed: Ohio State University (1982)
Action: 5/11/1999. Order issued lifting Consent Order of 5/22/1997.

PATEL, Aneel Nathoobhai, MD

Location: Goldsboro, NC (Wayne Co)
DOB: 8/12/1935
License #: 0000-34701
Specialty: P/N (as reported by physician)
Medical Ed: Seth GS Medical College, India (1959)
Action: 6/10/1999. Order issued lifting Consent Order of 1/04/1996.

STRICKLAND, David Keith, MD

Location: Blacksburg, VA
DOB: 12/10/1957
License #: 0000-33566
Specialty: EM/GP (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1987)
Action: 5/25/1999. Order issued lifting Consent Order of 2/14/1994.

VAN DYKE, Allen Holstead, MD

Location: Asheville, NC (Buncombe Co)
DOB: 4/05/1945
License #: 0000-17451
Specialty: OBG/OCC (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1971)
Action: 5/11/1999. Order issued lifting Consent Order of 10/23/1995.

VERNON, Charles Robertson, MD

Location: Wilmington, NC (New Hanover Co)
DOB: 8/21/1926
License #: 0000-09154
Specialty: P (as reported by physician)
Medical Ed: Case Western Reserve University (1952)
Action: 6/10/1999. Order issued lifting Consent Order of 4/15/1996.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

BRANCH, Robert Donald, Physician Assistant

Location: Kinston, NC (Lenoir Co)
DOB: 7/07/1958
License #: 1-02026
PA Education: University of Texas (1995)
Action: 5/21/1999. Full and unrestricted license reinstated.

BURSON, Jana Kaye, MD

Location: Mooresville, NC (Iredell Co)
DOB: 5/14/1961
License #: 0000-39164
Specialty: IM (as reported by physician)
Medical Ed: Ohio State University (1987)
Action: 7/23/1999. Temporary/dated license extended to expire 7/31/2000.

BYRUM, Christopher Edwards, MD

Location: Lake Wylie, SC
DOB: 10/19/1953
License #: 0000-35599
Specialty: P (as reported by physician)
Medical Ed: University of Virginia (1988)
Action: 7/23/1999. Temporary/dated license extended to expire 3/31/2000.

CHEEK, John Christopher, MD

Location: New Bern, NC (Craven Co)
DOB: 3/03/1957
License #: 0097-01906
Specialty: N/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 5/21/99. Temporary/dated license extended to expire 11/30/1999.

COLLINS, Natalear Rolline, MD

Location: Franklinton, NC (Franklin Co)
Louisburg, NC (Franklin Co)
DOB: 10/22/1955
License #: 0000-27108
Specialty: GP/FP (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1981)
Action: 5/21/1999. Temporary/dated license extended to expire 5/31/2000.

HALL, Jesse McRae, Physician Assistant

Location: Sanford, NC (Lee Co)
DOB: 6/23/1956
License #: 1-01830
PA Education: Fort Sam Houston, TX (1991)
Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

HARRIS, Donald Philip, MD

Location: Greensboro, NC (Guilford Co)
DOB: 4/09/1934
License #: 0000-13127
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1961)
Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

HOLTKAMP, John Harry, MD

Location: Raleigh, NC (Wake Co)
 DOB: 11/20/1954
 License #: 0000-28045
 Specialty: CHN/PD (as reported by physician)
 Medical Ed: New York University (1980)
 Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

KEEVER, Richard Alan, MD

Location: High Point, NC (Guilford Co)
 DOB: 6/11/1941
 License #: 0000-16400
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1969)
 Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

MASSEY, Howard Todd, MD

Location: Durham, NC (Durham, Co)
 DOB: 1/13/1963
 License #: 0098-01708
 Specialty: TS/GS (as reported by physician)
 Medical Ed: Medical College of Georgia (1990)
 Action: 5/21/1999. Temporary/dated license extended to expire 11/30/1999.

McKNIGHT, Martha Anne, MD

Location: Big Spring, TX
 DOB: 9/29/1955
 License #: 0000-26571
 Specialty: P/CHP (as reported by physician)
 Medical Ed: Duke University School of Medicine (1981)
 Action: 5/21/1999. Full and unrestricted license reinstated.

MEAD, Robert J., MD

Location: Asheboro, NC (Randolph Co)
 DOB: 12/13/1945
 License #: 0000-32790
 Specialty: PD/PDA (as reported by physician)
 Medical Ed: Jefferson Medical College (1978)
 Action: 5/21/1999. Temporary/dated license extended to expire 11/30/1999.

PATEL, Aneel Nathoobhai, MD

Location: Goldsboro, NC (Wayne Co)
 DOB: 8/12/1935
 License #: 0000-34701
 Specialty: P/N (as reported by physician)
 Medical Ed: Seth GS Medical College, India (1959)
 Action: 5/21/1999. Full and unrestricted license reinstated.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
 DOB: 5/05/1956
 License #: 0000-34548
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1990)
 Action: 5/21/1999. Allow temporary/dated license to expire as of 5/31/1999.

STEWART-CARBALLO, Charles Willy, MD

Location: Fayetteville, NC (Cumberland Co)
 McCain, NC (Hoke Co)
 DOB: 2/24/1957
 License #: 0000-38215
 Specialty: OBG/GP (as reported by physician)
 Medical Ed: University of Minnesota (1985)
 Action: 5/21/1999. Temporary/dated license extended to expire 11/30/1999.

THOMPSON, Robert Bruce, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 2/29/1956
 License #: 0000-40006
 Specialty: N (as reported by physician)
 Medical Ed: University of Miami (1987)
 Action: 7/23/1999. Temporary/dated license extended to expire 11/30/1999.

WANGELIN, Robert Lester, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 5/21/1945
 License #: 0000-28370
 Specialty: P (as reported by physician)
 Medical Ed: West Virginia University (1972)
 Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

WARD, David Townsend, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/07/1960
 License #: 0095-00473
 Specialty: ORS (as reported by physician)
 Medical Ed: West Virginia University (1986)
 Action: 7/23/1999. Temporary/dated license extended to expire 1/31/2000.

WEST, Harold Kenneth, Jr, MD

Location: Maitland, FL
 DOB: 4/21/1954
 License #: 0098-00437
 Specialty: FP/EM (as reported by physician)
 Medical Ed: Loma Linda University (1979)
 Action: 7/23/1999. Temporary/dated license extended to expire 7/31/2000.

DISMISSALS**CHARTIER, Stanley Earl, MD**

Location: Corona, CA
 DOB: 1/30/1924
 License #: 0000-17096
 Specialty: IM (as reported by physician)
 Medical Ed: Loma Linda University (1961)
 Action: 7/22/1999. Dr Chartier having died, the North Carolina Medical Board dismisses without prejudice the case initiated by the Notice of Charges of 3/10/1999.

GIRGIS, Sobhi Anis, MD

Location: Cordova, SC
 DOB: 7/24/1938
 License #: 0000-25913
 Specialty: GER/CHD (as reported by physician)
 Medical Ed: Alexandria University, Egypt (1964)
 Action: 7/22/1999. The Final Order of the South Carolina Board, on which the North Carolina Board based its case, having been reversed by the Court of Appeals of South Carolina, the North Carolina Board dismisses its case initiated by the Notice of Charges of 5/05/1995; the Consent Order between Dr Girgis and the Board is of no further effect, except those sections regarding the public nature of that Consent Order, and he is relieved of any continuing obligation thereunder.

KING, Joseph Aaron, MD

Location: Spring Grove, PA
 DOB: 9/20/1940
 License #: 0000-19798
 Specialty: AN (as reported by physician)
 Medical Ed: University of Tennessee (1965)
 Action: 5/3/1999. Dr King having had his license placed on inactive status for failure to register, the Board dismisses without prejudice the case initiated against him by Notice of Charges dated 3/22/1997.

RANGASWAMY, Avvari, MD

Location: Pikeville, KY
 DOB: 3/26/1948
 License #: 0000-22166
 Specialty: IM/NM (as reported by physician)
 Medical Ed: Jipmer, India (1970)
 Action: 7/22/1999. Dr Rangaswamy having died, the North Carolina Medical Board dismisses without prejudice the case initiated by the Notice of Charges of 2/17/1999.

See Consent Orders:

MINDER, Joseph Kamel, MD
SOROHAN, Jonathan Griffin

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type.

Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

☐ Business: _____

Phone: (____) _____ Fax: (____) _____

☐ Home: _____

Phone: (____) _____ Fax: (____) _____

The Board requests all licenses maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 60 days of a move.

IMPORTANT NOTICE: Annual Registration of Professional Corporations

The North Carolina Medical Board will mail annual registration forms for professional corporations to their agents of record during November 1999. All professional corporations should **register before December 31, 1999**. If the completed form and the required fee are returned to the Board between December 31, 1999, and January 31, 2000, a late fee of \$10.00 must be included. After January 31, 2000, corporate status is automatically inactivated for professional corporations that have not registered.

PLEASE NOTE: Professional corporation registration **does not** replace or serve in lieu of a licensed physician's, physician assistant's, or nurse practitioner's legal obligation to register individually within 30 days of his or her birthday. Registration of a professional corporation is an entirely separate process.



North Carolina Medical Board
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Raleigh, NC 27619

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